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MEDICAL



JOURNAL

OF AUSTRALIA

VOL. I.—14TH YEAR.

SYDNEY: SATURDAY, JUNE 25, 1927.

No. 26.

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THE MEDICAL JOURNAL OF AUSTRALIA

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Authors of articles submitted for publication are requested to read the following instructions and to comply with them.

All articles must be typed with double or treble spacing. Carbon copies should not be sent. Abbreviations should be avoided, especially those of a technical character at times employed in ward notes. Words and sentences should not be underlined or typed in capitals. The selection of the correct type is undertaken by the Editors. When illustrations are required, good photographic prints on glossy gaslight papers should be submitted. Each print should be enclosed in a sheet of paper. On this sheet of paper the number of the figure and the legend to appear below the print should be typed or legibly written. On no account should any mark be made on the back of the photographic print. If no good print is available, negatives may be submitted. Line drawings, graphs, charts and the like should be drawn on thick, white paper in India ink by a person accustomed to draw for reproduction. The drawings should be large and boldly executed and all figures, lettering and symbols should be of sufficient strength and size to remain clear after reduction. Skiagrams can be reproduced satisfactorily only if good prints or negatives are available. The reproduction of all illustrations but especially of skiagrams entails the sacrifice of

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Table of Contents

IThe Whole of the Literary Matter in THE MEDICAL JOURNAL OF AUSTRALIA is Copyright.]

ORIGINAL ARTICLES-	PAGE.	CORRESPONDENCE-	PAGE
"Listerian Oration, The Future of Obstetrics," by		Surgical Conscience	930
R. MARSHALL ALLAN, M.C., M.D., F.R.C.S.E.		Hernia	930
"Radiological Aspect of Diseases of the Colon," by J. G. Edwards, M.B., Ch.M.		Snake Bite	930
"Diseases of the Colon: The Surgical Aspect," by John Colvin Storey, O.B.E., V.D., M.B.	,	Crossed Swords	931
Ch.M., F.R.C.S	. 917	CONGRESS NOTES—	
REVIEWS-		Radiology	931
A Treatise on Exophthalmic Goître		OBITUARY-	
Diagnosis in Norvous Discussos	. 022	Arthur Frederick Parker	931
LEADING ARTICLES-			
Ultra-Violet Rays	. 923	ANALYTICAL DEPARTMENT—	931
CURRENT COMMENT-			003
Heterotopia	. 924	PROCEEDINGS OF THE AUSTRALIAN MEDIC	AL
BRITISH MEDICAL ASSOCIATION NEWS-		New South Wales	931
Scientific	. 926 . 927	Victoria	931
MEDICAL SOCIETIES-		BOOKS RECEIVED	932
The Alfred Hospital Clinical Society	927	DIARY FOR THE MONTH	932
POST-GRADUATE WORK-		MEDICAL APPOINTMENTS	932
Lectures in Launceston Melbourne Permanent Committee for Pos		MEDICAL APPOINTMENTS: IMPORTANT NOT	CE 932
Graduate Work		EDITORIAL NOTICES	932

Listerian Dration.1

THE FUTURE OF OBSTETRICS.

By R. MARSHALL ALLAN, M.C., M.D., F.R.C.S.E., Director of Obstetrical Research, University of Melbourne.

Before commencing my address I desire to express my warmest thanks to the Council of the South Australian Branch for the honour conferred on me, especially as this is the centenary of the birth of that great master whom we are assembled to honour tonight. I appreciate the compliment all the more since, as a representative of the younger generation, it was impossible to have had personal knowledge of those times nor to realize fully what such a change meant.

There is a peculiar propriety, particularly in this country, in celebrating the greatness of departed leaders since time soon dims the lustre of their achievements. Lethe, the river of oblivion, flows swiftly and rapidly obliterates what one generation regards as permanent landmarks. Today what does the name of Lister recall? Possibly the hazy recollection that he was a great surgeon or else memories of carbolic acid and the spray or dressings or some detail of surgical technique. But his reputation rests not on a new dressing, a lotion or on new methods of operating. He was the great pioneer who introduced new principles revolutionizing the pathology of inflammation and converting surgery from a name of terror to a bright ray of hope. As we read of the long years of struggle spent in the development and perfection of his system two things are noteworthy. In the first place, admiration must be given to the skill and ingenuity with which he applied the knowledge of his time to wound treatment. His experiments were never unscientific nor unreasonable and the steps taken were followed in proper sequence to a logical conclusion. Secondly, it surprises us that there could have been such bitter opposition from surgeons who did not even trouble to investigate the work personally. It is to the credit of the Scottish school that he had more supporters there than in the London stronghold which he was finally to subdue after a long and bitter fight. The renaissance of surgery began with the publication of a paper "On a New Method of Treating Compound Fractures, Abscesses, Etc.," in The Lancet in 1867. It was twelve years later before he was acclaimed the leader of the profession in Great Britain. Lamartine defined genius as the discovery or the application of a principle a little in advance of its time. The record of Lister fully bears this out.

The Obstetrical Forerunners of Lister.

Perhaps it is fitting that an obstetrician is addressing you at this time. It is human to imagine that there were no Greeks before Agamemnon, no antisepsis before Lister. Ideas of the transmissability of puerperal infection and the effect

. ¹ Delivered before the South Australian Branch of the British Medical Association on May 26, 1927.

of retained lochia in its causation were noted by Charles White, of Manchester, in 1772, and Gordon, of Aberdeen, in 1795. Collins, the first Master of the Rotunda to issue a report of his work (1826-1833), acknowledged the effect of White's teaching of ventilation and the use of chlorine to disinfect the wards. This was followed in 1843 by the famous paper of Oliver Wendel Holmes on "The Contagiousness of Puerperal Fever." Unfortunately Holmes did not persist owing to the violent opposition of the leaders of the profession in America, Four years later Semmelweiss after years of study stated that puerperal fever was caused by the absorption into the blood from the genitals of decomposed animal matter which was usually carried to the patient by the attendant, but might also be due to the patient herself. He further emphasized the similarity between surgical and puerperal fever. If "bacteria" be substituted for "decomposed animal matter" his definition would be quite modern. But these workers were not heeded and though getting near the truth, just failed to reach the goal. When Pasteur in 1857 published his epoch-making researches on fermentation, the significance of this work largely escaped the notice of the medical profession. Much of it was highly technical and apparently more concerned with brewers and wine producers than surgeons. The attention of Lister was not drawn to these papers until 1865. At once his master mind grasped the importance of Pasteur's researches into the problem of decomposition in exposed organic substances. From his previous knowledge of chemistry and histology he applied this new information to the antiseptic treatment of wounds. Thus the antiseptic system was founded on the germ theory of Pasteur. In characteristic fashion Lister acknowledged the source of his inspiration at that dramatic meeting in 1892 at the Sorbonne, when Pasteur rose to embrace the leader of the British scientific world who was conveying the homage of the medical profession to the great French chemist. Since 1867 the history of surgical and puerperal infection has been that of Listerism. Naturally the measures deemed necessary at first by Lister to combat sepsis did not appeal to the obstetricians. The spray was precluded largely from their field of operation. It was replaced by antiseptic douches, while lubricants impregnated with carbolic were employed for hands and instruments. Slowly the idea of asepsis supplanted the older theory and finally the two were combinedantiseptic preparation of the external genitals and of the hands with aseptic management of labour and the puerperium.

Obstetrical Conditions in Australia in the Pre-Listerian and Early Listerian Periods.

To appreciate properly the present status of obstetrics, especially in view of the frequent assertion that no improvement has occurred during the past fifty years, it is essential to have some know-ledge of Australian obstetric practice during the 'sixties and 'seventies. News travelled slowly then and the first account of Listerism as applied to obstetrics was published in 1876 by Dr. Jamieson. As in the hos

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pitals of Europe the mortality was very high. After twelve years at the Women's Hospital, Melbourne, Dr. Tracey in 1869 reported 3,421 deliveries with 41 deaths—a mortality of 12‰—and remarked that no better results could be obtained in the best private practice where any practitioner would be fortunate if he had not a larger percentage. In the following years the Women's Hospital had to be closed because of an outbreak of "scarlet fever and a low form of irritative fever." Between 1873-1879 the mortality rose to 13·79‰, whilst in one year (1873) it was actually 34‰ or one death among every 29 patients.

Conditions in private practice were not much better. The most detailed accounts were those of some Newcastle practitioners who had twenty deaths in 2,090 cases, equivalent to nearly 10% births. The literature gives vivid descriptions of the conditions of private practice. We must remember that the goldfields had attracted a motley crowd from all over the world. There was no Medical Act, quacks abounded and trained nurses did not exist. Professional ill-feeling was rife and, judging from the frequent suits for malpraxis, the general medical standards must have been low. There were repeated cases of uterine rupture due to the use of ergot in the second stage as well as to the application of high forceps. Traction on the cord was a common practice with some practitioners. At least three men were tried for manslaughter due to uterine perforation following craniotomy performed with a gimlet, auger, chisel and hook of telegraph wire as instruments. the principles of masterly inactivity were not always followed is well illustrated by a South Australian practitioner:

Expeditious delivery is unquestionably of advantage to the practitioner. The real objections to the forceps (I avoid such errors as including the cervix in the blades and pulling the uterus and all away as only possible in exceptional cases) are atony of the uterus and laceration of the cervix and perineum. Delivery may be expedited in accord with sound practice by using digital manipulations always, instrumental aid generally and drugs occasionally.

Another practitioner mentioned that in far the greater number of cases the old adage held good, namely "patience and a piece of tape are all that is required." Unfortunately he continued to describe a case of high forceps where after having divested himself of unnecessary clothing he began a long and steady pull. In 1860 there was a curious legal case for alleged unskilful treatment which showed that some laymen at least had glimmerings of the importance of postnatal examinations. Whilst giving a verdict for the defendant, three jurors considered that he should have examined the patient before finally leaving her. The editorial comment entitled "Speculative Law versus Practical Medicine" is illuminating:

Just fancy how indignant and justly so a patient would be if after recovery from her accouchement he were to say to her "you must allow me to make an examination to see if you are all right." Why if such a thing were to be spoken about the whole country would ring with the impropriety and indelicacy of this conduct.

The Present Position of Obstetrics.

Compared with the Listerian period we are fortunate in that there are regulations for medical and nursing practice, hospital accommodation has improved out of all recognition and good teaching facilities exist. While the mortality rate has decreased to a great degree in hospitals, the general maternal mortality rate has not dropped in the same ratio. Private practitioners who know from their own results that their records are good, cannot understand this failure of the statistical returns to reflect their own work.

The public are commencing to be alarmed at the unnecessarily high death rate and desire to know why obstetric practice has lagged so far behind surgical. Inquiries have been instigated in various English-speaking countries and the information used in this address has been obtained from a survey of the conditions prevailing in Victoria.

We may consider firstly that the modern returns are much more accurate than those of earlier days. Although the difference in actual figures does not seem great, it represents for Victora a decrease of 28% in the last decennium as compared with the period 1871-1880. In other countries much time has been wasted in futile arguments as to the degree of culpability of doctors and nurses or of the iniquities of the general practitioner as compared with his specialist confrère. With us the nurse can be excluded from at least a major share of the blame, as nine-tenths of all confinements are conducted at one stage or other under the guidance of a doctor. Nor are there so many specialists that their influence can have a great effect on the problem.

Tracing the evolution of obstetrics since the Listerian period, two distinct advances have been made. In the first place the greatest advance of all has been the recognition of the value of antenatal supervision with which the name of the late J. W. Ballantyne is so honourably associated. The proper application of these principles should practically abolish eclampsia and very greatly decrease the accidents of pregnancy and labour. As sepsis is mainly due to manipulative procedures consequent on abnormal labours, it too should be largely eliminated. The value of efficient and continuous antenatal and intranatal care is strikingly shown in the latest returns from the Women's Hospital. Among 1,281 patients with antenatal care only two deaths occurred. One of these patients did not attend regularly and in fact was admitted only after being in labour for a considerable time and badly infected. Compare this with 1,399 patients who were admitted as emergency cases in which the majority probably had very little supervision. Twenty-six deaths occurred in this group. On the whole antenatal supervision is improving rapidly and the general public have been educated to expect it. There is great need yet for its more general adoption in the industrial suburbs and in the country in particular. Secondly, there has been the gradual establishment of a more or less standardized technique as well as indications of the limitations of each obstetric procedure. At first obstetri-

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cians, following the teaching of Lister, played for safety and interfered as little as possible with Nature. Then various indications for operation were recognized. Slowly but surely obstetrics began to be recognized by many as a surgical procedure. Unfortunately this resulted in a host of fads, each claimed by its sponsor as a great improvement on Nature. Instead of regarding labour as a normal physiological process, writers referred to the "pathogenicity of parturition" and advocated a wide substitution of artificial for natural methods of delivery. Those in the forefront of this reaction did not realize that procedures which might be fairly safe in their hands, were fraught with great danger when performed by those who did not appreciate the risks involved. How frequently is a general surgeon called in to decide the method of surgical treatment to be adopted in a difficult case? As Whitridge Williams truly states, it requires a great deal more intelligence to decide to let a woman have a spontaneous labour through a contracted pelvis than to do any operation. Apart from questions of necessary or unnecessary interference during labour arises that of the aseptic conduct of parturition. The principles of asepsis and antisepsis are not complicated nor difficult to apply, namely the proper preparation of the external genitalia and the hands and the prevention of any non-sterile object coming in contact with puerperal wounds. Therefore, while we are in favour of labour being treated in a surgical fashion, if we are to reap the benefits surgery obtained from Listerism, this does not imply that surgical methods of delivery are to be used in every case. It means that we must prepare the field of operation as the surgeon does, conduct labours under favourable surroundings and have adequate assistance. The usual haphazard methods must be completely abolished before real improvement will be noted. In the Listerian days the main trouble after labour apart from sepsis was vesico-vaginal fistula due to the effect of prolonged labour. We have practically banished this, but the records of any gynæcological hospital plainly show that the incidence of prolapse, displacements and lacerations is no less now than formerly.

Now that surgical methods have almost reached a dead end, there is a growing tendency to invoke laboratory aid in the investigation particularly of the problems of pregnancy. Unfortunately the causation of the toxemias of pregnancy is still unknown and the results of blood chemistry and allied methods are of little practical value. We must still depend on accurate clinical observation and judgement. The same applies to the effect of pregnancy or the fœtus on the glands of the endocrine system. Much chaff must be winnowed to obtain the few grains of truth in the work published so far.

The Problems and Difficulties of Private Practice.

It has already been noted that while hospital conditions and records have shown definite improvement, the same principles of asepsis and antisepsis seem to have failed partially in private practice. So far in discussing the problem two factors only have been mentioned, namely the patient and the

attendant. In private work the environment of the delivery plays an important part. Why does the average woman unhesitatingly enter a properly equipped hospital for any surgical operation even of a minor nature and yet obstinately refuse to leave her home for an act which, though it may be normal, is certainly fraught with graver possibilities than many an abdominal operation? answer is to be found partly in tradition and the desire to be at home at such a time and partly in a tacit admission by the lay mind that obstetrics has none of the glamour of surgery and the consequent necessity for its performance in impressive and possibly expensive surroundings. As a profession we must make a united and decided stand and replace the majority of nursing homes with efficient hospitals. Then can we insist that all primiparæ, all patients requiring antenatal treatment or those needing obstetric operations as well as those with infection shall be treated under proper conditions. Surely what is considered essential for even minor surgery, is not beyond our obstetric ambitions. Once we can show what is to be gained by adequate treatment in proper surroundings, then it will not be so hard to convince those who have heard of the tragic occurrences in some of our smaller nursing homes. Meanwhile are we satisfied with the ordinary methods of preparing a patient for labour in a private house, particularly when no trained help is available? How often do we omit those precautions during labour without which no man would ever perform the simplest surgical operation? New Zealand can show us one way towards improvement by the provision of facilities for obtaining sterile obstetric outfits. Nor is the antiseptic preparation of the field of operation as perfect as it might be. Shaving or close clipping and the application of iodine or biniodide solution are not beyond even an untrained nurse. By attention to these small details the Women's Hospital was recently able to report a definite decrease in morbidity. Those who never wear gloves, but rely on antiseptics, may not get a roughened and cracked skin. But it would be better to prepare the hands just as carefully and then wear gloves which can be dipped in stronger solutions than any bare hand could stand. If coupled with these precautions which after all are the ordinary ones accepted for surgery, there is developed a disinclination to interfere except for real obstetric indications, a great advance will be made, thereby bringing domestic practice more into line with hospital methods. While the furore for operating has not reached the same height as in the United States, too many Cæsarean sections have been performed for various indications. The mortality associated with this procedure for placenta prævia and eclampsia in particular is greater than that following more conservative lines of treatment. Many operations, especially for contracted pelvis, appear to have been done because it was easier to say that the child could not be born any other way than to wait and see what Nature might be able to do. If further comment be necessary, let it be in the words of a Victorian country practitioner who wrote:

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Except for well defined indications the man who performs Cæsarean section without a trial of labour is either deficient in experience or honesty.

The use and abuse of forceps is a perennial topic especially in busy industrial practices. I commend the views of the Obstetric Staff of the Women's Hospital-that the commonest type of forceps application should be the "head on perineum" operation. In this the risk to mother and child is lowest, while any other type is associated with real risks. This attitude has been strongly confirmed by the recent investigations of Holland and Claypon concerning dead births and neonatal deaths. The frequency of intracranial lesions was high. Some were due to spontaneous breech labour, but the majority were associated with the use of forceps or the practice of podalic version. While such manipulations are often necessary, the high mortality suggests that our efforts should be directed towards a reduction of the need for obstetric interference.

The advocates of forceps maintain that more perineums are saved by their timely use and no morbidity follows their application. This is absolutely disproved by the records of both metropolitan and country hospitals. A request for more patience in the second stage does not mean advocating undue delay, but an intelligent prevention of pressure on both maternal and fætal soft parts by careful observation of the patient. A fair index of the value of the obstetric work of a hospital or an individual is the conduct of the third stage. Hurried tactics during labour are apt to be associated with similar methods later. The importance of a completely empty and well retracted uterus in the prophylaxis of sepsis still requires much emphasis.

Puerperal sepsis remains a vexed problem. It is directly responsible for at least one-third of the total mortality. Autoinfection undoubtedly plays a part, but my investigations in Victoria bear out the fact noted by British authorities that the majority of cases are associated with repeated examinations or injuries resulting from various obstetric operations. Closely allied with this topic is that of notification. It is not necessary to add anything to Dr. Hone's admirable paper in THE MEDICAL JOURNAL OF AUSTRALIA on the absolute failure of notification either as an estimate of the prevalence of infection or as a means of preventing its spread. Notification will never be of any use until it is backed up by practical help for the practitioner. This has already been done in England, notably at Hampstead and Bethnal Green. There are many factors in puerperal sepsis which have eluded research so far. We know little of the immunity of the normal pregnant woman, neither how to increase it nor how to recognize any diminution. At present puerperal sepsis can best be treated prophylactically by careful antenatal supervision, eliminating foci of infection and thus raising the general standard of health; by rigid asepsis during labour and the third stage and a minimum of operative interference and trauma to the tissues as well as by the avoidance of shock.

So far the mortality of childbirth has been discussed, but little has been said of morbidity. At least 50% of women bear some sign of weakened function after labour. The importance of a thorough overhaul six or eight weeks post partum has not been sufficiently appreciated by many men, nor has its value been impressed on the patients. The records of the Women's Hospital point out the need of such care, especially with nephritic patients and possible future pregnancies. Last year eleven out of twenty-eight deaths were definitely associated with nephritis.

The Influence of the General Public on the Problem.

So far those matters which directly concern the profession, have been discussed. Our own house needs putting in order, but the general public play an important part in the problem. One of the greatest obstacles to improvement is the attitude of the patient and her relatives. The modern city woman in particular desires to be delivered as speedily as possible without any heed to the cost to her future health. Unfortunately some men are only too ready to accede to this. It places too great a strain on those trying to do good work to see their patients flocking to one who "does not let them suffer." This desire to get it over quickly is not confined to the patient alone, but many a busy man admits that otherwise he would not get through with his day's work. This brings up the question of how many patients in confinement a doctor can honestly attend in conjunction with a general practice. The point does not arise in the country, but mainly in lodge practices in industrial areas. From my observations the best results have been shown by those who do not average more than one hundred to one hundred and fifty cases annually.

The "Gamp" and the handy woman seem to exercise a spell over many women to the detriment of the trained nurse. Too many men work with "Gamps" when skilled help is available. In this respect we cannot altogether blame the public, if they set a low valuation on obstetrics, seeing that their doctor does not demand skilled attention wherever possible and in suitable surroundings. That there is much inertia, indifference and even strong opposition to overcome is evidenced by the political reception of that recommendation of the Royal Commission on health that the maternity allowance be paid only to those applicants producing evidence of antenatal supervision. The reasonableness of this request is self-evident, but it will mean much spade work before it is put into effect.

The Relationship of Maternal and Infant Mortality.

It is well known that the efforts of those responsible for the reduction of the infantile death rate have been frustrated by the persistently high mortality for all ages under one month. This is almost entirely due to causes associated with pregnancy and labour. At least half the still-births and neonatal deaths are due to complications of labour and the toxemias of pregnancy. Those lost owing to labour difficulties are usually the healthiest and best developed and the very ones the State can least afford to lose. Therefore those measures already

stressed under antenatal supervision will have a definite effect on the infantile mortality under one month. There is need for efficient pathological laboratories with a trained staff at all large maternity hospitals to investigate fully still-births and neonatal deaths.

The Future.

I have endeavoured to show that in obstetrics we have failed to maintain and amplify the high standards set by Lister. Those standards are not impossible of achievement, even in an industrial suburb. But disunion and the apparent satisfaction of some men to be content with low standards must first be overcome. There are many signs in current literature that we as a profession are standing at the crossroads and soon must come to a decision. One road points to Government control with a fulltime service of obstetrical specialists, excluding the general practitioner from this branch of his work. Even if it be not completely taken from him, antenatal supervision will assuredly be assumed by State clinics and the first point of contact with the patient lost. Closely allied with such control will be compulsory interference with the choice of doctor, the rendering of official reports and returns and the supervision of actual medical attendance. The other path leads the way most of us would prefer to travel. But it means a complete change of attitude to that frequently seen at present. It implies wholehearted cooperation between general practitioner and specialist and a demand for and use of better hospital facilities. Expert obstetric care is required just as urgently as better hospital facilities. Frequently patients are not sent to hospital until it is too late to save the child and sometimes too late to save the mother also.

Many men when in difficulty do not call in those with special training but some friend, often a surgeon, with no special knowledge of obstetrics. Is it to be wondered at that under these circumstances the public are slow to realize that special skill is often necessary to insure the best results. Provided that the practitioner insists on thorough antenatal supervision, the conduct of labour under suitable conditions, the prompt attention to febrile patients backed up with specialist help if necessary, then to him will belong the main credit of improving the status of obstetrics and lowering the mortality rate. The nurse must work in cooperation and not as a competitor as is frequently seen in many suburbs. The time is hardly ripe yet for the division of work advocated by some British authorities, namely supervision during pregnancy by the doctor and delivery by the nurse alone except in abnormal

There are signs of the dawn of a new era which perhaps I can see more clearly than those engrossed in their more circumscribed sphere of work. The interest created and the very earnest assistance which I have received from men throughout Victoria, have been most encouraging. The younger graduates on the whole are endeavouring to carry out the ideals taught to them during student days. When Lister seemed to be surrounded by hostile

critics and detractors his most enthusiastic supporters were the younger generation. Similarly it is on them we pin our hopes for an obstetric revival. Lister was noted for his generosity in recognizing the work of his colleagues. We need more of that spirit today. When it becomes the rule that in cases of difficulty those with special knowledge will be consulted, then will more senior men continue to practise obstetrics and more younger men will be encouraged to qualify for positions requiring such skill.

Two of Lister's phrases are well worth remembering by all practitioners:

If a death should result from our carelessness or want of thought it is not far removed from manslaughter. To intrude an unskilled hand to such a piece of divine mechanism as the human body is indeed a fearful responsibility.

The great need at present is the arousing of an aseptic conscience in many who are dulled by the routine of practice and possibly affected by that fatalistic attitude characteristic of the Middle Ages when men felt overcome by circumstances and impotent to effect changes. We are still masters of our destiny and should be able to control external circumstances and not let them rule our fates.

Lister was a great and inspiring teacher. laid most emphasis on our personal responsibility and duty to our patients, the need to observe keenly and having once formed our own conclusions to act on them. We cannot stand still and simply enjoy the glorious tradition handed down to us. Rather must we become imbued with an active faith which will insist on overcoming the present obstacles while ever seeking new paths of advancement. Individually both in our own spheres of work and also in the circles which we can influence there is a call for the advancement of knowledge regarding the varied factors of the problem. Effective prophylaxis and treatment can be established only after further information obtained not only from laboratory and hospital observations, but in a great measure from the records of private practice. If this be done in a spirit of devotion to the great ideals of him whom we commemorate tonight, then surely will obstetrics take its vacant seat alongside surgery and medicine. Fortunate indeed is the country that can produce such men as Lister. When their race is run and the torch is handed on to us, what will its fate be

Let no man think that sudden in a minute
All is accomplished and the work is done;
Though with thine earliest dawn thou shouldst
begin it,
Scarce were it ended in thy setting sun.

RADIOLOGICAL ASPECT OF DISEASES OF THE COLON.

By J. G. EDWARDS, M.B., Ch.M. (Sydney), Honorary Radiologist, The Sydney Hospital, Sydney.

THE radiographic diagnosis of lesions of the colon is by no means easy and it should be attempted

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¹ Read at a meeting of the New South Wales Branch of the British Medical Association on May 26, 1927.

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only by the expert with a completely equipped laboratory at his disposal.

Fluoroscopy is probably more important than radiography, but the two methods should be combined if the best results are to be obtained. Enema examination is of greater value than the opaque meal in the diagnosis of pathological changes in the colon, but in most cases a combination of both methods is of value. The opaque meal will give information as to colonic mobility and as to abnormal positions of the proximal part of the colon. For lesions beyond the splenic flexure enema examination is necessary. The head of the opaque meal should reach the hepatic flexure in from six to eight hours and the splenic flexure in from twelve to sixteen hours. If these times are doubled, it means that a considerable degree of intestinal stasis is present.

Before an enema is given, the patient must be carefully prepared. A dose of castor oil should be given twenty-four hours before examination and an ordinary warm water enema about four hours before it. Morphine need not be given, as there is little risk of the patient failing to retain an enema if it is given slowly and if the patient is instructed to breathe freely through the mouth during its administration. Elaborate enema formulæ are unnecessary; one hundred and eighty grammes (six ounces) of barium sulphate and sixty grammes (two ounces) of powdered gum acacia are mixed to a paste with cold water and warm water is added to make 1.7 litres (three pints).

An ordinary douche can, fitted with a rubber or metal rectal tube, is used and the patient is allowed to insert this tube himself (this point is especially important if the patient suffers from hæmorrhoids or if he is of nervous temperament). The injection is made with the douche can elevated about sixty centimetres (two feet) above the patient's body. The rectum fills rapidly and is soon outlined with its valves of Houston, two on the left and one on the right.

It is only rarely that a rectal lesion can be demonstrated and when demonstrated, it is generally a well-advanced one. Proctoscopic examinations are of more value than X ray examinations in diseases of the rectum.

When the rectum is full there is a slight hesitation at the pelvi-rectal junction, but a little gentle palpation is followed by a rapid filling of the sigmoid and descending colons; the table may be tilted with the head low and this position helps in filling the sigmoid and descending colons.

There is some delay at the flexures, but gentle palpation is of value in helping the opaque enema onwards. Occasionally a spasm of about seven and a half or ten centimetres (three or four inches) of the middle of the transverse colon is met with, but this passes off in a few minutes, if the patient breathes deeply. When the enema fills the ascending colon, caecum and part of the ileum the flow is discontinued.

The colon is carefully examined for narrowing or obstruction, for filling defects which persist after

palpation, for fixation by adhesions and for irregularities in position.

Tuberculous disease of the caecum is accompanied by colonic hypermotility and caecal irritability and it is found that the caecum is unable to tolerate the presence of foreign material and at no point of examination can much of the opaque material be seen in the caecum.

Constant filling defects point to the presence of malignant disease and frequently a tumour can be palpated at the site of the defect. Several skiagrams should be taken and the constancy of the defect demonstrated.

Chronic colitis gives a peculiar smooth outline to the colonic shadow, due probably to loss of muscle tone from the chronic inflammatory changes.

Diverticulosis of the sigmoid is a common finding. In this condition the sigmoid colon is narrowed for several centimetres, it has a ragged outline and numerous small diverticula showing as dark areas outside the bowel lumen.

Hirschsprung's disease is demonstrable by enema and the lower part of the colon is shown in skiagrams as a huge broad shadow; even if two litres of solution are used, it is often impossible completely to fill the greatly distended gut.

In making bowel examinations, it is always necessary to be on the lookout for other lesions

The slides which I show tonight demonstrate several lesions accidentally discovered during bowel examinations, namely gall stones, renal calculus and a round worm in the ascending colon.

DISEASES OF THE COLON: THE SURGICAL ASPECT.¹

By John Colvin Storey, O.B.E., V.D., M.B., Ch.M. (Sydney), F.R.C.S. (England),

Honorary Surgeon, Royal Prince Alfred Hospital, Camperdown, Sydney; Honorary Surgeon, The Coast Hospital, Little Bay, New South Wales.

THE subject which I have the honour to introduce for your consideration tonight is the surgical aspect of diseases of the colon. It was intended, I believe, that the rectum should be excluded from the discussion, but I have found it scarcely possible to adhere to this desire, for diseases do not stop short at the anatomical junction of rectum and colon and as a matter of fact this very site is perhaps the most difficult of all for the surgeon from the point of view of treatment. However with your permission I shall arrive at a compromise and will endeavour to avoid too much detail as far as the rectum is concerned. It will be my aim as far as possible to give you impressions gained from experience and some of my opinions may not perhaps meet with undoubted approval of colleagues, but they will at least have the solid foundation of conviction born of practice. In addition, I propose to submit for your

¹Read at a meeting of the New South Wales Branch of the British Medical Association on May 26, 1927.

perusal an analysis of two series of cases occurring in patients under the care of various surgeons at the Royal Prince Alfred and the Coast Hospitals during a number of years. For the help of these two series, I am indebted to Dr. Millard, Superintendent of the Coast Hospital, and to Dr. Burton, my house surgeon at the Royal Prince Alfred Hospital and, of course, to all the gentlemen who cared for the patients.

Colonic diseases may be divided into congenital, inflammatory and neoplastic. Naturally, my own experience has mostly been of the last named.

CONGENITAL ABNORMALITIES.

Fortunately, it has not been my lot to encounter many congenital abnormalities, beyond having seen a caecum and appendix in a left inguinal hernia sac (in a case of complete transposition of viscera) and an acutely inflamed appendix in a man's right femoral sac, which I mistook for a strangulated femoral hernia.

The colon may be atresed or absent in any part of its course, but nearly all these patients die. May I remind you of Dr. Alan Walker's remarkable series of three successive children of the same family, who had complete absence of the lower sigmoid and rectum.

I have not encountered any of the embryologically interesting cases in which the rectum and anal canal fail to meet, nor have I met a single case of malrotation of the gut leaving the caecum on the left. A few cases of failure of the caecum to descend have been seen and I have noticed, as most of you no doubt have also, that the degree of attachment of the colon throughout its whole length is variable. I feel that this does not matter except in the case of twisting on the mesentery, that is the formation of a volvulus and I have, so far as I know, seen only one such and that in the commonest site, namely the sigmoid. This patient came to hospital with acute large bowel obstruction and I performed a right lumbar colostomy. A fortnight later I opened the abdomen, expecting to find a growth of the sigmoid, but to my surprise found a sigmoid with a very long mesentery and an exceedingly short attached end. Evidently the relief of tension by colostomy had allowed the gut to become undone. I am convinced that, had the abdomen of this patient been opened, he would have died. The sigmoid loop was excised at the second operation.

The various veils and kinks of the caecum that have been described are, I fancy, somewhat mythical.

I have not seen a case of congenital dilatation or Hirschsprung's disease.

INFLAMMATORY AFFECTIONS.

Inflammatory affections may be divided into acute and chronic.

Acute Inflammation.

During four years' service in the East I saw quite a number of patients with dysentery both amedic and bacillary. We used to notice that the stools contained as a rule more mucus streaked with blood in the former type and that tenesmus was very severe. In the bacillary type the general reaction was greater, temperature higher and the stools more inclined to be of the pea soup type. If in doubt of the cause and in the absence of an immediate examination of the stool by a skilled pathologist, we never hesitated to exhibit both emetine and antidysenteric serum.

Ulcerative Colitis.—By ulcerative colitis is meant ulceration of the colon not due to new growth nor specific infection. This has not come into my practice. Rare cases do occur, I believe, in which colonic inflammation is so intense that death of the whole thickness of the gut wall may occur.

Chronic Inflammation.

A few cases of chronic mucous colitis have been seen and these occur almost always in nervous individuals. I have had no experience of appendicostomy for these patients and the performance of this operation would require a lot of persuasion. A temporary colostomy on the right side would, I think, be more effective in resting the bowel; but probably the best thing is to treat the patient on general health lines, advising a change of climate and surroundings. Of course it is advisable in all these cases to exclude a specific infection and a neoplasm.

Woody Phlegmon of the Caecum.

I would like to draw your attention to a curious somewhat chronic form of inflammation seen in the caecum and sometimes called a hard, woody phlegmon. I remember meeting a case in which the end of the ileum and part of the caecum were so indurated that it was quite impossible to determine whether I was dealing with inflammation or new growth; but as the part was movable, I excised the affected portion of intestine and the pathologist reported "simple inflammation." Woody phlegmon is usually due to trouble in the appendix and when a caecum so affected is seen, the best thing is to close the abdomen at once as the inflammation will subside.

Tuberculous Ulceration.

In this country tuberculous ulceration is rare as regards the colon. I cannot recall a case, although I have seen some in the small intestine.

Syphilitic Ulceration.

Syphilitic ulceration occurs, but I have seen few instances. In all doubtful cases the Wassermann test should be done and the effect of antisyphilitic treatment tried. Syphilis seems to occur mostly at the lower end of the bowel. I have one patient just now who has existed for some years with a colostomy performed for chronic inflammation of the bowel from sigmoid to anus in which the lumen is almost obliterated and the gut wall very hard, and I am at a loss to know whether the condition is syphilitic, tuberculous or simple chronic inflammation.

Diverticulitis.

My own experience of diverticulitis is limited to two cases. one tonea opene patiet opera a few The result divert was a did no course his vertical to the course hi

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One patient had an abscess which burst all over the peritoneal cavity, and I drained the pouch of Douglas and opened the abscess externally and mirabile dictu the patient recovered only to die of a somewhat over-zealous operation on my part when I excised the offending bowel a few months later.

The second is still in hospital and was recorded as a result of X ray examination as suffering from "marked diverticulitis." On opening the abdomen, I found what was apparently a perfectly normal colon and of course did not interfere with it. He is recovering quite well. Of course, I admit freely that there may be diverticula in his very fat appendices epiploice.

These two cases will no doubt make your humble servant a little shy of operations for diverticulitis.

Dilatation of the Colon.

I have not met with a fatal case of dilatation of the colon per se. Frequently in cases of small bowel distension I cast a purse string of fine silk in the bowel wall and plunge a trocar and cannula attached to the suction apparatus in the centre and when the bowel collapses, I withdraw the cannula and tie the purse string. I find that this procedure is very useful indeed. The other day in operating or a gastric ulcer, I was bothered by great distension with gas only of the colon whose wall was healthy, and the same method was used with happy results.

CANCER OF THE COLON.

Especially in hospital practice cancer of the colon is fairly common and if only we could get the patients earlier, the results would no doubt be better than they are at present. I confess at once that, although treatment in some cases is wonderfully encouraging, the path of the surgeon dealing with these patients is beset with pitfalls and disappointments. The great difficulty is that an early diagnosis has been hitherto wellnigh impossible and competent surgeon relatively early, they would lend themselves to brilliant results.

Types.

It is customary in some textbooks to divide the growth into proliferating, scirrhous, infiltrating and colloid with increasing degrees of malignancy in that order. So far as my own experience goes, the division is purely arbitrary; they all start in the mucous membrane and the pathologists tell us they are adenocarcinomata. The degree of virulence varies as in cancer elsewhere in the body. An increase in proportion of cellular content signifies an increase in the degree of malignancy and yet I do not think that the operative appearance nor the opinion of the pathologist can forecast with any accuracy the probability of glandular or metastatic infection.

As a general rule it may be stated that glandular infection is late and that wide local dissemination except in the case of the colloid variety which rapidly spreads through the peritoneum, is unusual. Even when the peritoneal coat of the bowel is invaded, the outlook is not necessarily grave and sometimes when the growth is fixed to the parietes, that fixation is inflammatory and does not render

the condition inoperable. From the patient's point of view the scirrhous type is the best, for it forms a ring stricture often almost as though a piece of string had been tied round the bowel and so causes obstruction and makes the patient seek advice.

Signs and Symptoms.

Signs and symptoms have been most variable and vague. Pain of varying character, accompanied by some change in the bowel habit, mostly an increasing difficulty of keeping the bowels open, seems to be the most constant. If there be no obstruction, then the growth may be absolutely symptomless.

My own experience has been and this is borne out by the series, that the frequency in situation increases from the caecum to the rectum and the nearer the rectum, the more likely there is to be some alteration in the function of defæcation, in particular a call to stool with an inability to complete the act.

The presence of blood is not very common in colonic growths, but fairly frequent in rectal At present many patients come to hospital with either chronic or acute obstruction. Some of these will complain of recurring attacks of spasmodic pain and will even trace out the wave of pain as it passes along the bowel and will describe a weird noise heard as the gas goes through the narrowed lumen. The situation of the pain is sometimes misleading; for example a growth of the sigmoid will cause distension of the caecum. I have actually seen the caecum burst from back pressure in such a case. Such pain will be accompanied by tenderness in the right iliac fossa and lead to the old favourite, appendicitis, being diagnosed. I remember being led into this trap with the aid of a senior colleague.

I was rung up by the house surgeon and told that Dr. So-and-so had seen a patient with acute appendicitis and thought he should be operated upon. On arrival at the hospital, I found a man with a history of abdominal pain and tenderness in the right iliac fossa and promptly robbed him of his appendix. He did quite well, but returned a few weeks later with acute obstruction from a sigmoid growth.

X ray examination after a barium enema seems to hold out the best hope of an early diagnosis and here let me warn you that the shadow is not always the same as the substance. It apparently requires considerable experience on the part of the radiographer to enable him to give a reliable opinion of a barium enema. The mere fact that the barium does not go beyond a certain level is not of much significance, as Dr. Sear has often told me. Moreover, filling defects are sometimes seen by the enthusiastic, when they do not exist.

The sigmoidoscope for the lower part of the bowel, when carefully used, should be a help. Personally, I have not much experience with the instrument. A well-known physician once asked me to examine a patient's splenic flexure with a sigmoidoscope. This, of course, is quite impossible. Any rigid instrument must be passed carefully under the protection of actual vision of its progress in the bowel and moreover a soft rectal tube should never

be inserted more than seven and a half centimetres (three inches). It will always curl up. This has been clearly proved by more than one X ray expert.

The lesson that seems to be learned is that any patient, particularly if of middle age, who complains of an alteration of bowel habit or vague pains in the abdomen, should be examined in the most thorough manner by palpation, combined palpation and auscultation, rectal examination, sigmoidoscopic examination, examination of fæces, barium enemata followed by X ray examination and after careful consideration of the mental attitude of the patient an exploratory laparotomy. Of course, any wave of enthusiastic investigation of this disease is bound to lead to unnecessary operations, but with care these could be reduced to a minimum. combined auscultation and palpation method is especially useful in cases of obstruction. It is subject to fallacies, but it is often possible to map out distended colon and to hear a peculiar high pitched note as contents rush from distended bowel to narrowed lumen.

As a general rule it may be stated that the presence of visible peristalsis causing a ladder pattern indicates small gut obstruction rather than large. The small bowel occasionally can be seen contracting when the actual cause of the block is lower down in the large bowel.

The Operation.

The actual operation should be considered under two headings: (i) cases with obstruction of any degree and (ii) cases without obstruction.

Operation in the Presence of Obstruction.

In my opinion a blind colostomy is the only operation worth considering in the presence of obstruction. A laparotomy may satisfy the surgeon's curiosity about the site of the growth, but stands a very good chance of killing the patient. Distended large bowel will not stand handling. The value of a right lumbar colostomy was most dramatically impressed upon my mind by Sir Alexander MacCormick in a patient brought to him by a practitioner when I was Sir Alexander's assistant in 1912 and 1913.

This man was as close to death as a patient could be. His limbs were cold and blue, his abdomen was blown up as tight as a kettle-drum and his pulse almost imperceptible. I was the unfortunate deputed to give the anæsthetic and the mere turning on his side almost finished the patient. However, Sir Alexander rapidly opened the ascending colon, the abdomen came down like a pricked balloon and at once the patient improved and recovered to have a colloid cancer successfully removed from the splenic flexure a fortnight later.

It has been my practice lately to use a local anaesthetic when the patients are very ill. This method seems to me to be safer and except in the case of a very fat patient, lumbar colostomy is not a difficult operation. I shall not weary you with the details of the procedure. These may be found in textbooks. It is much nicer to fix a Paul's tube in the gut with a running suture and, provided the tube has a good flange, it will stay in position for several days quite as long as the fæces remain fluid. I generally fix the Paul's tube to the skin with a clove hitch of fishing gut. In passing, I would commend to you

Paul's article on intestinal obstruction in Volume II of Binnie's "Treatise on Regional Surgery." May I point out that, given a case of large bowel obstruction, if the surgeon works merely on the law of chance, an opening in the ascending colon will be above the growth in about 96% of cases, according to the site incidence in the Prince Alfred Hospital series over a number of years.

What should be done when the abdomen is opened and greatly distended large bowel encountered? The answer is, recognize your mistake, close the abdomen and perform lumbar colostomy, except in rare cases where the bowel you meet is obviously almost burst. In these circumstances, the safest thing is to wall off with sponges and plunge a fair-sized trocar and cannula attached to a suction apparatus into the bowel and empty it if possible and then stitch a Paul's tube into the opening of the bowel and also fix the bowel to the peritoneum. Anastomoses in the presence of acute obstruction are almost sure to fail.

Operation in the Absence of Obstruction.

Even in the absence of obstruction a preliminary colostomy, especially in cases of rectal cancer that can be removed from below, renders the treatment much safer. In rectal growths, if the colostomy is to be permanent, it is, of course, done in the left inguinal region.

In colonic cancer the ideal seems to be complete and wide excision of the growth and juxtaposed glands with a long side to side anastomosis. However, an end to end junction works quite well, provided it is snugly performed. A large Murphy's button is safe only where the bowel is entirely surrounded by peritoneum.

In removing portion of large intestine, it is essential that the surgeon should be quite satisfied that the remaining bowel has an adequate blood supply.

I remember only too well a few years ago doing an excision of cancer of the large intestine and a side to side anastomosis and feeling a little pleased with my work, till at the very end of the operation I remarked to the house surgeon that I did not like the colour of the bowel—it had seemed a little pale. The patient did very well for four days and then suddenly went to pieces. Post mortem the anastomosis had been demonstrated and leaking.

There are rules laid down giving points at which to ligate arteries, but from a practical point of view it is best actually to see the small terminal loops pulsating and the bowel a healthy red colour. The actual anastomosis and distribution of blood supply vary. It is a safe rule, however, that if the middle colic be tied, all the transverse colon must be removed.

In the rectum any growth which can be fully palpated per rectum should be removed from below after a preliminary laparotomy in which the liver is palpated for secondary deposit and the pelvic and aortic glands examined. A left inguinal colostomy is then performed, the actual removal of the growth being done a fortnight later. Growths at the top of the rectum and the lower end of the sigmoid are best treated by combined abdomino-perineal method and let me warn you that in a male who is fat and

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has a long narrow pelvic basin, the operation is probably the most difficult in surgical practice.

Interesting Cases.

May I recall one or two remarkable cases?

A female, aged fifty years, was first seen six years ago with an urgent abdominal condition at the Royal Prince Alfred Hospital. Laparotomy revealed a cancer of the hepatic flexure. As there was no obstruction, I excised and performed a Murphy button anas-tomosis. A few days after the operation I discovered that the patient had sixteen years previously been operated upon by Sir Alexander MacCormick for rectal cancer by the sacral route, the growth had been pronounced adenocarcinoma by Professor Welsh and the woman had subsequent to that operation given birth to five children. After the excision of the hepatic flexure (six years ago) she was very well till a few weeks ago when she got a pain in the epigastrium while hanging clothes on the line and felt a lump at the same site. She presented her-self for examination, still looking fat and well and a movable mass was palpable, so I advised laparotomy. Unfortunately, the tumour proved to be a mass of glands round the cellac artery and there were deposits in the liver.

A female, Mrs. E.T., aged fifty-two years, first came under notice at the Coast Hospital eighteen months ago with a history of one recent attack of abdominal pain and a second of a few days' duration culminating in absolute constipation. On examination I found she had large gut obstruction and performed right lumbar colostomy. A few weeks later laparotomy revealed a descending colon in which polypi were palpable through the bowel wall and suspecting that there would be a growth above, I found such in the descending colon and higher up another at the splenic flexure, the latter being the real cause of obstruc-tion. I removed bowel from the middle of the transverse colon to the lower part of the sigmoid, doing an end to end anastomosis. On the bowel subsequently being opened, polypi were seen to be present right up to the line of my incisions at noth ends (see accompanying figure). The patient did very well, but the colostomy would not close, so a few weeks ago I opened the abdomen again and found a third growth right at the site of my previous anastomosis. I suppose the stitching had stirred the cells of the polypi into activity.

I have at least in two other cases met a double carcinoma in different parts of the great bowel.

The youngest patient whom I have treated with large bowel cancer was a blacksmith of twenty-seven, for whom I did an abdomino-perineal resection for

cancer of the rectum. He returned to his trade and was quite well two years after the operation and is still, so far as I know. The oldest is a gentleman

of eighty-seven, on whom I performed right lumbar colostomy for sigmoid growth eighteen months ago. He has an hypertrophied prostate, an inguinal hernia and very "pipe stem" arteries and as he nearly died of uramia at the time of colostomy, I

have advised against excision. The patient leads quite a tolerable existence, but is able to afford the luxury of a nurse.

Fish Bone Case.

Some two years ago a very well nourished man of about forty was admitted with all the signs of obstruction. I was unable to determine whether the large bowel or the small bowel was involved and proceeded to do a laparotomy. On reaching the peritoneum, I felt what was apparently a growth of the sigmoid, hard and fixed to the parietes, so I closed the incision at once and performed right lumbar colostomy. When I opened the abdomen a fortnight later, the growth had vanished, but there were numerous adhesions about and on separating the bowel, out jumped a fish bone of the large schnapper variety. Evidently this had perforated the sigmoid and set up an intense inflammatory action which put the bowel out of its normal function. The man made an uninterrupted recovery and I subsequently closed his lumbar colostomy.

Statistics.

Cases of the colon (excluding rectum) treated at the Royal Prince Alfred Hospital from November, 1912, to December, 1926, are as follows:

								150
								74
								76
								30
								14
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								59
								Years.
								55
								80
	,							27
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There were 150 patients with cancer of the rectum at the Royal Prince Alfred Hospital during the period 1910 to 1926.

The Coast Hospital series for the period 1922 to 1926 is as follows:

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Ca	ar	ce	r	of	tl	1e	re	ect	uı	m				44
Ca	ır	ce	r	of	th	le	co	lo	n					44
Ca	ı	ce	r	of	th	e	bo	we	el					5
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Figure Showing Polypi in Colon Removed at Operation.

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Patients died

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Patients unrelieved

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The site of the growth in the Royal Prince, Alfred Hospital series of 150 cases is as follows:

Caecum and ascending	ng	col	on	 	 	23
Hepatic flexure				 	 	2
Transverse colon				 	 	21
Splenic flexure				 	 	5
Descending colon				 	 	21
Sigmoid colon				 	 	63
						15
Total				 	 	150

The signs and symptoms in the Royal Prince Alfred Hospital series are as follows:

						Cases
Pain						38
Pain and constipation						17
Pain and vomiting						10
Pain and mass palpable						9
Pain, constipation and vomi						3
Pain, constipation and mass	s pal	pabl	e			3
Pain, constipation, vomiting				alpa	ble	. 1
Pain and indigestion						3
Constipation						20
Diarrhœa						18
Constipation and diarrhea						6
Blood in fæces						18
Constipation and mass palp						3
Indigestion						4
Distension						4
Weakness						î
Admitted unconscious						1
Previous colostomy					* *	4

It will be seen at once, especially as the standard of cure is merely discharge from hospital in apparent good health, that the results in both series of cases are far from satisfactory and that cancer of the large intestine in the present state of our knowledge is a very fatal disease. The only hope of improvement lies in early diagnosis.

Reviews.

A TREATISE ON EXOPHTHALMIC GOÎTRE.

"Exophthalmic Goître" by Dr. John Eason presents most of the modern work on the subject in a readable way.1 The author has no original view to propound, unless it be that the symptoms and signs of exophthalmic goftre are not due to over-action of the sympathetic nervous system alone, but to a general cell over-activity in which the sympathetic neurones participate. He asserts that many symptoms and signs, on the contrary, are due to parasympathetic over-activity. He considers that the relative preponderance of the sympathetic or the parasympathetic in each individual case depends on the autonomic balance of the patient (whether vagotonic or sympatheticotonic) irrespective of the development of the exophthalmic This merely exaggerates the autonomic phenomena in common with over-activity of every other the body. It is this increased metabolism due to hyper-oxidation that he regards as the disease syndrome. The author is attracted by the views of Williamson and Pearse on the histopathology of the thyreoid. He reproduces their conceptions immediately he has described the older view. This doubtful acceptance of the more modern conceptions results in a certain indefiniteness in the book noticed most in classification. Nevertheless he reserves some scorn for the "so-called toxic adenomata" and prefers the term "multiple nodular hyperplasia." Incidentally he does not warn against the danger of the administration of iodine in this condition.

In the chapter on pathogenesis he makes statements that are profoundly true. "The fundamental conception of exophthalmic gottre is that it is a disorder which is due to a kinetic vicious circle. A priori this may have its beginning at any link in the chain of the vicious circle." Again: "Of exciting factors by a very long way first in importance are those that operate through the motional centres of the brain." In the chapter on prognosis he says: "The spontaneous course of the average case of primary exophthalmic goltre is towards gradual arrest provided the individual is not again exposed to any exciting causes of the syndrome." As evidence of this he speaks of a discussion in which every speaker reported at least one cure without any of the methods of treatment being identical. On page 155 he writes: "It is necessary to deduct from the alleged benefits of all forms of treatment that amount of improvement inevitably associated with rest."

When he deals with treatment he urges removal of focal sepsis on the principle indicated by the proverb concerning the last straw.

He places removal of emotional strain first in importance; physical rest a close second. Iodine (the administration of which is well described) is also advocated. "Insulin" is advised in emaciated patients when acidosis generally is present, but in doses less than thirty units per diem.

When medical treatment fails, the author is very firm in his advocacy of subtotal thyreoidectomy. When surgery is impossible he prefers radium to X rays on account of the emotional effect of the noise and mystery of the latter agency.

The illustrations are numerous, the photography is good and the book is well printed. It has an extensive bibliography. Altogether it is a valuable book for any practitioner. The criticism concerning indefiniteness is perhaps carping, considering the gaps in our knowledge of causation in this interesting syndrome—a link between mind and body.

DIAGNOSIS IN NERVOUS DISEASES

THE third English edition of the compendium written by Professor Robert Bing, of the University of Basle, translated from the sixth German edition by Dr. F. S. Arnold, has come to hand.¹ To neurologists the work needs no introduction, to others we may indicate that it deals with the applied anatomy and physiology of the central nervous system in special reference to localization. The plan is to take the divisions of the central nervous system seriatim -spinal cord, midbrain, cerebellum, cerebrum, basal ganglia and hypophysis—look at the anatomy and physiology of each and show what must result clinically if this or that structure or part is damaged or destroyed. correctness of the teaching principle will not be denied. It must be obvious that it is just as impossible to locate disease in the nervous system without knowledge of structure and function, as it is for the surgeon to operate without anatomy or the physician to prescribe without pharmacology. But there is a drawback which applies pharmacology. But there is a drawback which applies to all works of this kind, and it is that just as ordinary anatomy and physiology cannot be learned without dissection and demonstration, so and even more so the intricacies of the nervous system cannot be learned from the book alone. Accordingly, although we look upon this as an excellent compendium, well-conceived, accurate and copiously illustrated, we cannot but feel that its use will be restricted to specialists and to special students of the nervous system in contact with a teaching school or a mentor such as Professor Bing. The translator in conmentor such as Professor Bing. The translator in conveying his meaning with perfect clearness throughout has done so well that occasional lapses into German construction may be overlooked.

^{1&}quot;Exophthalmic Goître," by John Eason, M.D., F.R.C.P.E.; 1927. Edinburgh: Oliver and Boyd. Royal 8vo., pp. 227, with illustrations. Price: 12s. 6d. net.

¹ "Compendium of Regional Diagnosis in Affections of the Brain and Spinal Cord," by Robert Bing, Translated from the Sixth German Edition by F. S. Arnold, B.A., M.B., B.Ch. (Oxon.); Third Edition; 1927. London: William Heinemann (Medical Books), Limited. Crown 4to., pp. 219, with illustrations. Price: 15s. net.

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The Wedical Journal of Australia

SATURDAY, JUNE 25, 1927.

Altra-Violet Rays.

Before the commencement of the present century light and heat were employed to a certain extent as therapeutic agents and both were recognized as sources of pathological changes. It was assumed that the action of the two agents was the same. Erythema solare was regarded as a special form of heat effect and no attempt was made to distinguish between sun burn and fire burn. On the other hand it was generally taught that lentigo was caused by direct or diffuse sunlight, not heat, stimulating the pigment activity, especially in summer time when this activity was greatest. Hebra, however, challenged the sunlight hypothesis on the ground that freckles occurred at times in unexposed areas of skin. The discovery by Röntgen of X rays at the end of the nineteenth century marks the beginning of a serious study of the physiological action of light and other rays on the living organism. There were many observed facts to guide the investigator in his search. Exposure to sunlight is followed by varying alterations in the skin and in the body, some of which appear to be beneficial and others deleterious. The nature of the changes appears to be determined partly by the quality and extent of the sunlight and partly by the protective powers of the organism. The curative action of sunlight in tuberculous lesions of the bones, joints, skin and possibly also the deeper organs can be traced to a definite bactericidal effect of rays at the violet end of the spectrum and beyond. If the sunlight exposure is prolonged and intense, the skin reacts by becoming hyperæmic, swollen and tender. The erythema may be so severe that destruction of the epidermis and even of the cutis vera may follow. The irritant action of sunlight has been proved to be largely effected by ultra-violet rays, although red and infra-red rays may contribute to the reaction. It would appear that the formation of freckles and slight degrees of sun burn pigmentation represents an incomplete response on the part of the organism to protect itself against the dam aging effects of ultra-violet rays. In the next place the combined committee of the Lister Institute of Preventive Medicine and the Medical Research Council discovered in the course of the inquiry into the nature of rickets in Vienna that ultra-violet rays play an important part in the maintenance of calcium metabolism. Children exposed to sunlight were cured of their rickets or the disease did not appear, notwithstanding the fact that they were fed on diets deficient in the antirhachitic accessory food Sunlight filtered through glass windows does not have this effect. In other words the action cannot be attributed to actinic rays, but is obviously a result of ultra-violet irradiation. The study of the therapeutic action of Finsen light or other forms of so-called artificial sunlight has led to the accumulation of data in connexion with the whole subject. Last week we published a very valuable article by Dr. E. H. Molesworth on rodent ulcer. In this article he adduces strong evidence in favour of an interesting hypothesis. It is that lupus rulgaris is rare in Australia because the abundant sunlight in this part of the world provides sufficient ultra-violet rays to prevent the growth of tubercle bacilli in the skin. In England where exposure to intense sunlight is intermittent and of short duration, lupus is very common. On the other hand redent ulcer, he shows, is common among persons who are exposed to the direct action of the blazing sun in Australia. It occurs on those parts of the body which are the least protected, such as the cheek, while epithelioma which is histologically similar to rodent ulcer, occurs on the lower but not on the upper lip. It is unnecessary to restate Dr Molesworth's case; he has given his arguments in a most admirable manner. From this evidence and from much that has been collected before, it may be concluded that ultra-violet rays exert a bactericidal action which becomes manifest at some depth from the surface, that they stimulate calcium and phosphorus metabolism, that they accelerate tissue change in the skin and to some extent throughout the body and probably that they further the secretion of the endocrine glands, especially the para thyreoid glands. In the next place these rays may give rise to a hyperæmic reaction in the skin and

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subcutaneous tissue of varying intensity. If the organism responds in a protective manner, pigment may be deposited in the skin in one form or another. If the tanning is dense, it may act as an adequate barrier to the passage of the ultra-violet rays. If the protection of pigment is absent or insufficient, the rays may stimulate and irritate the tissue cells which lie in their path. The result of excessive stimulation by ultra-violet rays like X rays is hyperplasia with ultimate disorderly overgrowth.

The work of Moppett has demonstrated that the stimulating effect of X rays is not a question of overdose so much as of rays of particular wave lengths. If monochromatic X rays of a certain wave length act primarily as destructive agents and those of another wave length act as stimulants to overgrowth of cells, it would be reasonable to expect the same selective action of ultra-violet rays. These rays have a wave length of from 2,100 and 3,800 expressed in Angström units. The range is therefore wide and the possibility that rays of varying wave length induce physiological responses of varying kinds cannot be lightly brushed aside. It is known that ultra-violet rays do produce a variety of changes, some health-giving, some protective, some mildly harmful and some grossly deleterious. This problem should be studied from the point of view of the physical properties of rays extending beyond the violet end of the spectrum.

Current Comment.

HETEROTOPIA.

THE word heterotopia is derived from the Greek έτερος, other and τόπος, a place. A heterotopic tumour, therefore, is one in which the cell structure differs radically from that of the parent tissue. Tumours of this nature have a double interest. They may be looked at first from what may be called the academic point of view-how it comes to pass that cells are "out of place." There is also a certain clinical interest centralizing around the relationship of the heterotopic tissue to pathological changes in the parent tissue and the possible changes which the heterotopic tissue may undergo. In October, 1923, heterotopic tumours were discussed in these columns in connexion with work by Nicholson. Nicholson concluded that there are no reasons against the assumption that heterotopic tumours originate in the epithelial cells of the organs in which they are found. Their histiogenesis is to be

explained by metaplasia, a dedifferentiation, followed by an atypical redifferentiation of differentiated cells and not by displaced cell rests or other congenital malformations. The epithelial heterotopic tumours of the alimentary tract have recently been investigated by A. L. Taylor. He has studied one hundred and thirty heterotopic tumours. One hundred and ten were received from the operation theatre and post mortem room of the Leeds General Infirmary and twenty came from outside the institution. Sixty-nine were gathered during the period of study and this fact is quoted as evidence of the frequency of the condition. He divides heterotopias into two main classes, superficial and deep. In the former the process is merely one of substitution in the epithelial lining of the gut and does not involve the deep layers. The epithelial structures of the alimentary canal with the exceptions of the mucous glands of the esophagus and Brunner's glands of the duodenum, are confined strictly to the inner side of the muscularis mucosa. Thus glandular structures present beneath this muscular boundary (with the two exceptions already mentioned) must be regarded as deep heterotopia. Epithelial heterotopia may make its appearance in embryonic life when the intestinal epithelium is actually growing or it may arise after birth following local destruction of tissue by inflammatory processes. It may thus be congenital or acquired. This classification is useful. The congenital heterotopias appear to be confined almost without exception to the upper portion of the alimentary canal. Taylor dis-cusses those in his series in considerable detail. In the first place it must be pointed out that in the superficial congenital heterotopias there is a substitution of a portion of the mucous membrane by areas of mucous membrane foreign to that part, but normal to some other intestinal region. They invariably manifest an adult structure. The deep congenital heterotopias also contain only those types of cell which are normally found in some region of the alimentary tract. The structure is varied and the most frequent constituent is pancreatic tissue. In some of the adenomyomata a lack of differentiation may be manifest.

In regard to the clinical significance of this condition some points of importance are noted. In one instance a tumour-like mass was found in the ileum about twenty-five centimetres from the ileo-caecal valve. The mass consisted of tall gastric glands almost entirely of the fundal type and rich in oxyntic cells. On one side there was a sharp transition to glands of the intestinal type and on the other side near the site of junction there was found an extensive ulceration involving the muscularis mucosæ. The ulceration occurred not in the aberrant glands, but in the adjacent normal intestinal mucosa. An explanation offered is that an acid secretion formed by the heterotopic glands may have devitalized the neighbouring epithelium and rendered it susceptible to an infection which would otherwise have been easily overcome. This is. of course, pure conjecture. Obviously the fundal

¹ The Journal of Pathology and Bacteriology, April, 1927.

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oxyntic cells had something to do with the ulceration. It is interesting to consider what part hormonic control would play in these circumstances. Presumably the heterotopic gastric cells would be under the same hormonic control as those of the stomach. At the same time the free surface of the mass of tissue would be bathed by an alkaline instead of an acid medium. The question might naturally be asked as to why ulceration was confined to one side of the implanted mass and also as to why ulceration does not occur more frequently in association with gastric heterotopic tumours in the intestine. If the cause of gastric ulceration were definitely known, it might be possible to answer these questions and conversely, if these questions could be answered, they would shed light on the cause of all forms of intestinal ulceration.

Another observation of clinical significance was made in connexion with intestinal gland heterotopia of the stomach. Intestinal heterotopia was found in thirty-six of a series of one hundred and fifty eight stomachs removed at surgical operation. In the "vast majority" of these a typical long history of symptoms leading to a diagnosis of gastric ulcer was present and partial gastrectomy was performed. Significance is attached to the fact that all the examples in the series were discovered accidentally during routine microscopical examination stomachs removed surgically for ulcer or cancer. Although the association with gastric ulcer and malignant disease has to be considered in connexion with acquired heterotopia, it must be pointed out here that Taylor gives several reasons against the existence of any relationship between superficial heterotopia and gastric ulcer and malignant disease. In the first place in five out of eighteen stomachs examined with this object in view, areas of heterotopia were found in parts of the stomach remote from the ulcer. In only two of the thirty-six cases were the intestinal glands found at the edge of the ulcer. In the remainder they were some distance away from the crater and manifested no inflammatory change whatever. Heterotopic areas in a stomach are usually multiple and chronic gastric ulcer and carcinoma are usually single. Gastric uleer is usually found in the middle third near the lesser curvature and carcinoma near the pyloric region, but heterotopic areas may occur in any part of the organ. The differentiation of the heterotopic areas is complete and the arrangement is as normal as in the intestinal mucosa. Moreover, since primary carcinoma of the small intestine is very rare, it is extremely unlikely to arise in epithelium of the intestinal type, even though this is found in the stomach. Such are Taylor's reasons for disclaiming any relationship between these conditions, but it may be noted that the same questions in regard to hormonic control may be asked here as were asked in connexion with gastric heterotopia in the small intestine.

In discussing acquired heterotopia Taylor points out that what he calls the regenerative type of deep acquired heterotopia arises in the walls of destructive lesions of the stomach by the rapid growth of newly-formed epithelium. In an examination of one

hundred and twenty-six stomachs he found tissue of this type thirty-three times. He states that growth, whether physiological or malignant, must have its origin in undifferentiated cells, since complete differentiation is incompatible with growth. He holds that islets of heterotopic epithelium of the sort described by him have not infrequently been mistaken for malignant disease. In this way he accounts for the statement that 60% to 70% of chronic gastric ulcers show histological evidence of malignant disease. This will be of interest to readers of this journal in view of the fact that Devine has recently thrown down the gauntlet to those who claim that cancer supervenes on chronic gastric ulcer. Taylor admits that malignant disease does supervene on chronic gastric ulcer in a certain number of cases, but the evidence in his opinion suggests that it does not take origin in a malignant transformation of heterotopia, but in an atypical growth of undifferentiated cells which are not represented in the heterotopic tissue. In other words malignant disease is independent of heterotopia, but both conditions may arise in destructive lesions.

The only point remaining for discussion is Taylor's view of the origin of heterotopic tumours. He regards the congenital heterotopias as dysontogenetic structures, that is, structures arising in the individual from abnormal differentiation of the embryonic entoderm when this is compelled by abnormal stimulation to follow an atypical course of development. This view is somewhat similar to that expressed by Nicholson. At the same time he points out that in their distribution and in their antimesenteric situation the congenital heterotopias correspond closely with the diverticula occurring in the intestine of the embryo. He holds that they arise from embryonic diverticula which abnormally persist. If this is so, the subsequent process cannot be one of "abnormal differentiation," it is not far removed from that which would occur according to Cohnheim's embryonic cell rest theory. Taylor has not made his position sufficiently clear. He cannot have it both ways. Probably he means to indicate that in some cases diverticula may persist and go on developing and that in others an abnormal differentiation occurs, but he does not make this statement. In regard to the superficial heterotopias of acquired origin he holds that they are produced by an error of differentiation in the regenerative process accom-panying ulcerative lesions. They spring from the "indifferent" cells normally present, when under abnormal stimulation there is a reappearance of an alternative cell character which was previously latent. The question to be decided is whether they result from an abnormal response to a normal stimulus or from a normal response to an abnormal stimulus. In either case the result will be a tissue different from that surrounding it, in other words a so-called heterotopia. If, however, the result is dependent on an alternative normal response, the appearance of latent characteristics, as a result of an abnormal stimulus, in other words if the process is one of prosoplasia, it will be correct to state that the final tissue is not fundamentally a true heterotopia.

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SCIENTIFIC.

A MEETING OF THE NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Building, 30-34, Elizabeth Street, Sydney, on May 26, 1927, DR. F. BROWN CRAIG, the Acting President, in the chair.

Radiology and Diseases of the Colon.

Dr. J. G. Edwards read a paper entitled: "Radiological Aspect of Diseases of the Colon" (see page 916). He illustrated his remarks by a series of lantern slides in which were depicted the appearances resulting from the administration of bismuth meal and opaque enemata.

DR. H. R. Sear also demonstrated by means of lantern slides a series of skiagrams. He dealt with congenital abnormality, incipient malignant disease, colitis, the various stages of diverticulitis, intussusceptions and so forth.

Surgery of the Colon.

DR. J. COLVIN STOREY, O.B.E., read a paper entitled: "The Surgical Aspects of Diseases of the Colon" (see page 917).

PROFESSOR F. P. SANDES said that he had enjoyed both the papers and the demonstrations. So many points had been brought up that it was possible to refer merely to a few of them. The classification of diseases of the colon adopted by Dr. Storey was eminently satisfactory from the practical point of view. It was one which he always taught to his students. He was reminded by Dr. Storey's reference to embryological abnormality of one patient with an interesting history. Operation had been performed by Dr. Clubbe sixteen years previously for intussusception. The patient's parents had stated that caecum and appendix were removed at the time of this operation and the history and location of the scar certainly suggested this probability. Laparotomy had then been performed for subacute intestinal obstruction with temporary relief. Two weeks later obstruction occurred again and during operation a normal caecum and appendix had been found in the neighbourhood of the spleen. It was also necessary to remember the "pancreatic" position of the appendix and the occasional left iliac fossa position. In regard to the membranes mentioned by Dr. Storey, Professor Sandes thought that they occurred more frequently than It had been taught that they were the result of old inflammation, but it should be recognized that they were due to persistence of peritoneal folds which had not atrophied. Cases of diverticulitis might easily be missed if the diverticula were packed with fæcal material, for in these circumstances the opaque enema could not pass into the diverticula. In regard to the treatment of diverticula he recalled two cases in which cure had been effected by colostomy. One patient, a well-known artist, had been operated on at Saint Bartholomew's Hospital, London, in 1901. A diagnosis of inoperable carcinoma had been made, but after the performance of colostomy the thickening had disappeared. Undoubtedly this was a case of unrecognized diverticulitis.

Professor Sandes congratulated Dr. Storey on the fact that his paper had not been a textbook dissertation, but was concerned with his own experiences and those of others with whom he had been associated. For this reason they should be grateful to him. He did not agree that the operation of right lumbar colostomy should be performed in all cases of acute obstruction. Had he had charge of Dr. Storey's patient with the fish bone, he would probably have explored the mass. Nevertheless Dr. Storey had obviously played for safety. He was in entire agreement with Dr. Storey's remarks on anastomosis of distended bowel. It was very important, especially for young surgeons, to recognize that only a minimum of actual work should be done in these circumstances. It would appear that in the presence of chronic obstructions some patients developed a certain amount of resistance to their own coliform organisms. If at the operation the peritoneum was fouled and a suitable drain was put down to the affected area, the patient generally recovered.

Dr. H. C. RUTHERFORD DARLING congratulated the authors on the high standard of their papers. He had been interested

in diseases of the colon for some considerable time. Dr. Edwards had recently made a diagnosis for him in ten or twelve cases of diverticulitis. This could not be looked upon as one identity. It occurred in various stages. There was the diverticulum which sloughed and gave rise to general peritonitis. In this type it was often impossible to close the perforation owing to the stitches cutting out and the inflamed portion of the colon had to be excised. In the presence of extensive pericolitis, especially when a large area of bowel was involved, a colostomy was frequently performed. This allowed the inflammatory process to subside slowly, but the resulting fibrosis of the bowel in a position of rest frequently led to difficulties being encountered in the subsequent endeavours to close the colostomy and reestablish the continuity of the colon. He had himself been caught in this trap and the patient had to be left with a permanent colostomy owing to the lumen of the distal portion of the bowel being practically obliterated. In many of these cases he had had success with the operation which Dr. Storey so despised, appendi-When this operation was performed, the patient could be taught to wash out his own bowel. An improvement occurred, but Dr. Darling did not know why. Dr. Edwards had controlled the results obtained. In ulcerative colitis appendicostomy was of the utmost value. He had operated on a patient at the Coast Hospital for Dr. Will-The patient had passed as many as twelve to twenty-four bloody stools a day and he had been cured by appendicostomy. In conclusion Dr. Darling referred to the question of lumbar colostomy. This operation was attended by two disadvantages. In the first place it was frequently followed by cellulitis of the loin. In the second place it was difficult to make a satisfactory spur; hence not only did fæces tend to pass into the distal lumen, but the opening also tended to close. Furthermore the surgeon was unable, should the general condition of the patient permit, to examine the site, nature and extent of the obstruction. For these reasons the operation had been abandoned and abdominal colostomy or caecostomy had been adopted.

Dr. Archie Aspinall thanked Dr. Storey for the way in which he had dealt with the subject. He had hoped to bring forward some statistics in regard to the results obtained at the Sydney Hospital, but had been unable to do so. He could, however, assure those present that they were as depressing as those quoted by Dr. Storey. The age of Dr. Storey's youngest patient was twenty-seven. Aspinall had had one patient of the same age. She had been perfectly well until symptoms of obstruction occurred. He had operated and had found a cancer of the transverse colon with extensive involvement of the glands. He had excised the growth and had left a blind end in the ascending colon and in the splenic flexure. The patient had had a mobile sigmoid colon and he had anastomozed the caecum and the sigmoid. He had been afraid that the blind ends would prove disadvantageous and act as sinks. All had gone well, however, and the patient put on weight and the bowels acted without difficulty. After three years she had come to see Dr. Aspinall and had been apparently quite well, but six weeks later she had been admitted with secondary deposits throughout the abdomen. Another patient had been admitted with acute intestinal obstruction due to cancer of the hepatic flexure after being treated by a physician for gastritis, all the symptoms coinciding with that view. No X ray examination had been made. A right lumbar colostomy had been performed and a Paul's tube after insertion had slipped out and symptoms of obstruction recurred. The lower portion of the wound had been reopened and a catheter inserted into the distended bowel which proved to be ileum. After a few weeks the patient's condition was much improved and the abdomen had been opened again. On this occasion the malignant tumour was removed, together with the lower portion of the ileum, the ascending and large portion of the transverse colon, a wide lateral anastomosis being performed. The wound had healed by first intention. After three years no recurrence had been found. Dr. Aspinall held that this case illustrated the life saving property of enterostomy and the immunity acquired by patients to coliform organisms was shown by the wound at the second operation healing so well.

Dr. Aspinall then referred to diverticulitis and to the history of a patient whom he had seen in the out-patient department. He had shown this patient to a group of students as suffering from typical appendicitis with an abscess formation. Immediate operation had been undertaken and it was expected that the omentum would be found wrapped round an acutely inflamed appendix or abscess. To his surprise the appendix had been normal and the condition was due to an inflamed appendix epiploice due to a small diverticulum which was removed. Dr. Storey's account of the discovery of a fish bone reminded him of a case in which he had opened the abdomen of a patient after a diagnosis of malignant disease of the sigmoid was made as a result of X ray examination. diagnosis of malignant disease of the sigmoid was made. The patient's temperature had been raised and Dr. Aspinall had found a tumour of the sigmoid as large as a closed had found a tumour of the signoid as larges a closed fist attached to the parietal peritoneum. On examination the mass had appeared to be largely inflammatory and while he was wondering what to do, he had felt something like a needle in the bowel just where it entered the tumour. He had pushed this through the wall and found it to be a wooden tooth pick. He had closed the abdomen and the patient made a good recovery. The patient had been dining not wisely but too well and while drinking a cocktail had evidently swallowed the tooth drinking a cocktail had evidently swallowed the tooth pick attached to an olive. On his discharge the patient had promptly got drunk and after three months was admitted in a state of diabetic coma and died. At post mortem examination the only abnormality found in the abdomen was an adhesion or two in the neighbourhood of the sigmoid, showing how completely an inflammatory mass disappeared.

DR. P. FIASCHI referred to the question of control of a temporary or permanent iliac colostomy and demonstrated a simple apparatus, readily made, which he had elaborated a number of years previously for probably the first abdomino-perineal extirpation of the rectum and pelvic colon with a permanent iliac anus performed in Australia by his father. It consisted of the pneumatic face piece of an ordinary ether inhaler fitted to a flat piece of brass of its own shape forming a pad. The outer surface of the metal portion of the pad was provided with tags to which the snap hooks of an elastic belt were attached. In conclusion Dr. Fiaschi congratulated Dr. Storey on his paper and referred to the operation of appendicostomy. He had seen Weir, of New York, perform the first appendicostomy. This operation had been aptly described by Weir as "a new use for the useless." When Murphy's buttons were extensively used twenty-five years previously in America house surgeons had been taught to examine the rectum every day after the seventh day, because the button frequently lay for some time in the ampulla of the rectum.

Dr. Storey in reply referred to the way in which Sir Arthur Keith had without mentioning names emphasized his belief that Lane was wrong in regard to kinks of the bowel. It was his opinion that their importance had been very much overdone. In reply to the remarks of Professor Sandes on the fish bone case he said that if Professor Sandes had seen the condition of the patient's abdomen, he would certainly have refrained from exploration. In reply to Dr. Darling he admitted that right lumbar colos-tomy was an old-fashioned operation, but it was the best. It might occasionally cause some cellulitis. The cellulitis, however, was not severe and did not endanger the patient's life. The advantages were the rapidity with which it could be performed, the fact that excessive handling of the patient was avoided and that at a second operation the surgeon had to deal with what was practically a virgin abdomen. No adhesions would be present and operation would not be difficult. His faith in the operation had not been shaken. In regard to Dr. Aspinall's remarks about the immunity to coliform organisms, he said that they had all seen cases in which on opening the abdomen the bowel was found to be gangrenous. If there was inflammatory reaction around the area, if it was walled off and adequate drainage was provided, the patient would do well, as far as immediate prospects of life were concerned. Dr. Storey congratulated Dr. Fiaschi on his apparatus for permanent colostomy. He held that a permanent colostomy was more satisfactory than repair by Kraske's operation. The bowel could be trained to act and the patient got quite used to the condition of affairs.

NOMINATIONS AND ELECTIONS.

THE undermentioned have been nominated for election as members of the New South Wales Branch of the British Medical Association:

Lieberman, Hyman Barnett, M.B., Ch.M., 1926 (Univ. Sydney), 41, Darley Road, Randwick. Unwin, Maurice Leslie, M.B., Ch.M., 1925 (Univ. Sydney), Southwinds, Burrawong Avenue, Clifton Gardens.

Culey, Arthur Charles, M.B., Ch.M., 1926 (Univ. Sydney), Karula, Neirbo Avenue, Hurstville.

Wedical Societies.

THE ALFRED HOSPITAL CLINICAL SOCIETY.

A MEETING OF THE ALFRED HOSPITAL CLINICAL SOCIETY WAS held at the Alfred Hospital on May 31, 1927.

Poliomyelitis.

Dr. W. S. Laurie showed a boy, aged five years and eight months, who had been admitted to hospital on April 23, 1926, after four days' illness. Examination had revealed complete paralysis of the right leg with absent tendon reflexes and paresis of abdominal muscles on both sides and of the gluteal and back muscles. Severe pains had been present in the right shoulder and arm, but no paralysis. Lumbar puncture had revealed seventy-one lymphocytes per cubic millimetre and a diagnosis of poliomyelitis was

On the following day thirty cubic centimetres of serum for poliomyelitis had been given by intravenous and ten cubic centimetres by intramuscular injection. The condition had gradually improved and massage and reeducation of paralysed muscles was instituted. At the time of the meeting the patient could walk well and had some power in all muscles, but there was still weakness in certain muscles. The right knee jerk had returned.

Dislocation of the Head of the Radius.

MR. H. C. COLVILLE showed several patients who had suffered from anterior dislocation of the head of the radius with fracture in the upper third of the ulna. Three children had had injury to the upper extremity resulting in frac-ture of the upper third of the shaft of the ulna with forward dislocation of the head of the radius. The first was a boy of nine who had been brought to the hospital on February 4, 1927, immediately after an accident. Clinical and X ray examination had revealed the abovementioned lesion. He had been operated on a few days later and the head of the radius was found to be reducible by combined flexion and traction on the forearm, but the displacement was found to recur unless the elbow was kept This position had accordingly been mainfully flexed. tained, while the ulna fracture was exposed and the fragments brought into opposition and fixed by a stout catgut suture through two drilled holes. Full flexion had been maintained during the first four weeks of the after treatment and thereafter active movements had been instituted. At the time of demonstration (four months after opera-tion) the elbow was normal from the anatomical and functional points of view.

The second patient was a girl of seven who had had an accident one year before she was brought to hospital. The fractured ulna had united, but the head of the radius was still dislocated. She had been operated on and the capsule of the elbow joint opened through a postero-lateral incision. The anterior part of the capsule had been incised from within and the head of the radius pulled back

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into position through the opening. Full flexion had been maintained during the after treatment. At the time of showing (four months after operation) the head of the radius was in almost normal position, but there was some limitation of both flexion and extension of the elbow joint as a whole.

The third patient, a child of two, had the same history and findings as the second child, but had not yet received any treatment

Mr. Colville said that these patients demonstrated the importance of early treatment of this condition, if a good result was to be obtained. Suggestions were asked for as to any more satisfactory method of dealing with late cases of dislocation of head of the radius.

Mr. A. J. Trinca congratulated Mr. Colville on his results and advised that the third patient be left alone, as his arm was almost functionally perfect and in accordance with Wolfe's law a surgeon would expect considerable adaptation of structure and function in a child of only two years,

Legg's Disease.

Mr. A. J. Trinca showed a patient suffering from Legg's disease of both hips. The patient, aged twelve years, had a history of wasting of the left lower limb which had been noticeable for thirteen months. The child fell when he tried to run and walked with a limp and had pain in both hip joints. Anæmia and loss of weight were present. No history of hernia could be obtained.

Inquiry disclosed the fact that the child had been breast fed for three months and then in the words of his mother had been "nearly killed by artificial food." Examination revealed wasting of the left lower limb, 3-5 centimetres in thigh, 2-0 centimetres in calf and shortening of 1-75 centimetres. Abduction was slightly limited and painful. All other movements of the left hip were normal, there was tenderness over the posterior portion of the capsule of the hip joint. The right lower limb was entirely normal. X ray examination revealed very broad necks of both femora with coxa vara and flattening of the epiphyses. The acetabulum had a mamillated appearance on both sides. The condition was interesting on account of the light thrown on the ætiology of infantile malnutrition. As suggested by Calvé there was a possibility of this condition being rhachitic.

Mr. A. C. Colville discussed the traumatic and infective theories of Perthes's disease. He pointed out that the diagnosis was made by X ray examination and he did not think there was sufficient evidence to justify a diagnosis in the patient shown.

Dr. W. S. Laurie said that in his opinion the skiagram shown was lacking in essential points for the diagnosis of Perthes's disease. The modern opinion seemed to be in favour of a mild infective origin for Perthes's disease.

A Case for Diagnosis.

Mr. H. C. Trumble showed a patient with multiple lumps on the left forearm for diagnosis. The patient was a man aged thirty-three, who had noticed multiple small lumps about the size of peas under the skin of his left forearm for the past two years. There was neither pain nor disability. During the two years since the lumps had first been noticed, he thought that more than five had appeared and he was certain that the group as a whole had shifted from the radial to the dorsal side of the forearm.

On examination the nodules were found to be small, fatty, pea-like, apparently developed in the deep fascia on the dorsal and radial aspects of his right forearm.

No opinions as to diagnosis were offered and Mr. Trumble agreed to excise one of the lumps for pathological examination and to report the findings to the next meeting of the Society.

"Lipiodol Ascendens."

DR. J. F. MACKEDDIE showed films illustrating a failure of ascent of "Lipiodol ascendens." The patient had been suspected of having a spinal tumour; "Lipiodol ascendens" had been injected by lumbar puncture and had risen to the cervical region where it had appeared to be blocked. As

this finding was not in accordance with the clinical picture, heavy "Lipiodol" had been injected by cisternal puncture and X ray examination showed that it dropped straight to the bottom of the spinal canal carrying the "Lipiodol ascendens" with it.

The technique used was that recommended and practised by the originators of "Lipiodol ascendens" and in view of this case Dr. Mackeddie urged caution in the diagnostic interpretation of skiagrams showing arrest of "Lipiodol ascendens" used for the location of spinal tumours.

Cerebral Tumour.

Dr. Mackeddie showed another patient suffering from a cerebello-pontine angle tumour with vermicular symptoms. The patient had an unsteady gait of a type suggesting a lesion of the *vermis* with involvement of the cranial nerves. Apart from the gait the limbs and trunk were neurologically normal.

The third, fourth, fifth, sixth and eighth cranial nerves on the right side were completely paralysed. The seventh nerve on the left side was affected and there was definite evidence of pontine involvement. No reaction had occurred to the Wassermann test.

He thought the condition was one of cerebello-pontine angle tumour or of a tumour of the *vermis* and he intended to recommend deep therapy as the most hopeful method of treatment.

Post-Graduate Work.

LECTURES IN LAUNCESTON.

A POST-GRADUATE COURSE was held at the Launceston Public Hospital from June 2 to June 4, 1927, Dr. H. D. STEPHENS, Honorary Surgeon to the Children's Hospital, Melbourne, giving lectures and demonstrations. The course was largely attended by the practitioners of the city and surrounding districts.

Abdominal Conditions in Children.

On June 2, 1927, Dr. Stephens gave a clinical lecture on "Abdominal Pain and Difficult Abdominal Conditions in Children." He save a general description of acute appendicitis and said that there were three signs of great value: (a) A coated tongue, (b) an offensive breath, (c) localized rigidity of the abdomen. This latter he thought was the most important sign, he emphasized the fact that the temperature was rarely over 38-9° C. (102° F.). He discussed the different positions of the appendix with the corresponding difference in the symptoms and signs.

In regard to the differentiation of pneumococcal peritonitis from appendicitis the following points were of importance: (a) A history including diarrhea, (b) the bright flush on the face, (c) the high pulse, (d) the raised respiratory rate, (e) a clean tongue and a non-offensive breath

He said that if he were sure of his diagnosis he would not operate in a case of pneumococcal peritonitis until a localized abscess had been formed. In discussing acute pyelitis, he emphasized the fact that a febrile condition and a fractious irritability might be the only manifestations. An examination of the urine differentiated the condition.

He had operated for appendicitis on some patients suffering from early enteric fever. The condition found at operation was interesting, there being ædema of the Peyer's patches with little dilated venules over them.

He had frequently seen acute appendicitis associated with the acutely inflamed tonsils. There was another condition in which the appendix was normal, but the mesenteric and retroperitoneal glands were acutely inflamed and even contained pus. This condition was very difficult to differentiate from a condition in which tuberculous glands in the right iliac fossa had become secondarily infected. Sores on the legs might also cause inflammation of glands in the right iliac fossa which might be mistaken for appendicitis.

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In discussing supradiaphragmatic lesions Dr. Stephens pointed out that paeumonia was frequently mistaken for appendicitis. The following points were of importance in differentiation: (a) The appearance of the child, (b) the rapid pulse rate, (c) the respiration was increased out of proportion to the pulse and temperature, (d) the tongue was clean, (e) the breath was not offensive, (f) a careful palpation of the abdomen revealed no tenderness, (g) the leucocytes numbered between thirty and forty thousand per cubic millimetre, (h) the vesicular murmur at one base was diminished.

Pericarditis might also be mistaken for an abdominal condition. Salpingitis was not uncommon in girls with a vaginal discharge and was usually gonorrheal.

Congestion of the ovary occurred in girls in a premenstrual period. There was acute pain above the symphysis, accompanied by a little fever, a furred tongue, constipation and on rectal examination tenderness on both sides.

The distinguishing features of intestinal colic were: (a) The colicky pain, (b) pressure relieved the pain, (c) the number of leucocytes was not raised.

These were the main conditions to be differentiated. Other conditions he had met were: (a) Renal colic, (b) pain from a tuberculous spine, (c) pain from a psoas abscess, (d) iliac abscess from a sore on the foot or from acute arthritis of the hip, (e) gastric crises from cerebrospinal syphilis in children over ten, (f) lead poisoning.

Dr. Stephens then discussed certain difficulties met with in infants including pyloric stenosis, certain food disturbances and certain congenital abnormalities. This part of the lecture was illustrated with pathological specimens.

Clinical Demonstrations.

On June 3, 1927, in the morning Dr. Stephens visited the children's ward and gave a series of clinical demonstrations. The conditions discussed included a tumour in the chest, an associated tuberculous joint and gland and a case of probable pink disease.

Conditions of the Hip.

In the evening Dr. Stephens lectured on "Certain Hip Conditions in Children." The following conditions were discussed: Tuberculous hip disease, the full clinical picture was described and the criteria of cure were discussed; congenital dislocation of the hip; paralysis of the limb, causing limp and suggesting hip disease; pneumococcal arthritis; osteomyelitis; syphilis; hæmophilia; scurvy; Perthes's disease.

Dr. Stephens illustrated his lecture with many skiagrams and later demonstrated model splints used in the treatment of the conditions.

Splint Measurement.

On June 4, 1927, in the morning Dr. Stephens visited the children's ward and gave a demonstration on the measuring of children for splints.

Vote of Thanks.

At the conclusion of the course Dr. C. G. Thompson proposed a vote of thanks to the lecturer and was supported by Dr. G. E. Clemons and Dr. J. Ramsay. The speakers paid a tribute to the manner in which Dr. Stephens had handled his subjects, and to the extent of the ground which he had covered. They emphasized the extreme importance of the periodical visits of men from the big teaching centres to isolated places such as Launceston. The visits of such men as Dr. Stephens had a very stimulating effect on practitioners who were cut off for months from medical men other than themselves.

MELBOURNE PERMANENT COMMITTEE FOR POST-GRADUATE WORK.

The Melbourne Permanent Committee for Post-Graduate Work has been able to arrange through the courtesy of Dr. MacEachern, of the American College of Surgeons, a special visit by two distinguished Americans, Dr. Allen Kanavel, of the Cook County Hospital, and Professor Charles Elliot, North-West University, Chicago.

Dr. Kanavel is world-famous for his monograph on infections of the hand and for numerous other contributions to surgical literature.

Dr. Elliot is recognized as one of the leading physicians of North America and has contributed much to the know-ledge of diabetes, jaundice and diseases of the thyreoid and spleen

Dr. Kanavel will lecture on surgical problems connected with the hand, wrist and forearm and on some other surgical subjects. Dr. Elliot will lecture on diseases of the thyreoid and on jaundice. These lectures will be illustrated by lantern and cinematographic pictures.

The lecturers have only a limited time at their disposal, but each will give six lectures at the Medical Society Hall on the following dates:

 Tuesday,
 August 23, 8.15 p.m.—Dr. Elliot.

 Wednesday, August 24, 8.15 p.m.—Dr. Elliot.

 Thursday, August 25, 8.15 p.m.—Dr. Elliot.

 Monday, August 29, 8.15 p.m.—Dr. Elliot.

 Monday, August 29, 8.15 p.m.—Dr. Elliot.

 Tuesday, August 30, 8.15 p.m.—Dr. Kanavel.

 Wednesday, August 31, 8.15 p.m.—Dr. Elliot.

 Wednesday, August 31, 8.15 p.m.—Dr. Elliot.

 9.15 p.m.—Dr. Elliot.

 Wednesday, August 31, 8.15 p.m.—Dr. Kanavel.

In addition the Committee has made arrangements that during the fortnight members attending this course will have access without extra charge to all the routine work in the in-patient, the out-patient and special departments and in the operating theatres of the various metropolitan hospitals.

The fee for this course of twelve lectures is five guineas.

During the same period the annual course in obstetrics will be held at the Women's Hospital, Carlton, and members of that course may, if they wish, attend the special course in the evenings, on payment of the additional fee.

The Honorary Secretaries, Dr. J. W. Dunbar Hooper and Dr. Harold R. Dew, would be pleased to accept applications and receive subscriptions (which should be paid in advance) as soon as possible in order that they may know the number of practitioners likely to attend.

WINTER COURSE IN OBSTETRICS.

THE annual winter course of post-graduate work in obstetrics will be held at the Women's Hospital, Melbourne, from August 22 to September 5, 1927. The course comprises attendance in all the departments of the hospital for routine work, as well as at special lectures and demonstrations by members of the staff. Arrangements have been made whereby a limited number of graduates can enter into residence at the hospital.

The fees for this course are three guineas for clinical work, demonstrations and attendance at lectures and four guineas in addition for board and residence at the hospital per week.

It is hoped that members taking the course will avail themselves of the fact that it will be concurrent with the special series of lectures to be given by Dr. Allen B. Kanavel and Dr. Charles Elliot and endeavour to attend both courses.

Further details may be had from the Honorary Secretaries, Dr. J. W. Dunbar Hooper and Dr. Harold R. Dew.

Correspondence.

SURGICAL CONSCIENCE.

Sir: Into the controversy regarding the establishment or otherwise of a College of Surgeons I do not wish to enter, except in regard to principle. The motive behind this movement is obviously one of conscience, desiring to protect humanity from being submitted to maltreatment in incapable hands. What I desire to ask is, why is this conscience confined to supposedly incompetent surgeons? Fresh from my several hundredth experience of encountering advanced and untreatable disease rendered so by the delay involved in the machinations of a herbalist, I in-quired of one of the promoters of the present surgical scheme why are charlatans allowed to spread their nets without interference by our senior men. The answer was: "Why protect fools from their folly?" Surely it is a shortsighted viewpoint which realizes humane considerations in one situation and not in the other and inconsistency at once arises if one situation is dealt with alone. Personally I find experiences such as the following intolerable and humiliating. Thus a leading commercial man, despite his protests, has found that he must submit to his wife visiting a Chinese for a nervous breakdown. Accompanying her for weeks to the charlatan's rooms he found difficulty in gaining admission on account of the rush of clients. Among these is an individual who was diagnosed four years ago as suffering from renal calculus, the diagnosis being confirmed by X rays. For this period the sufferer allowed himself to be convinced by the Chinese that the stone can be "dissolved." The pain being intolerable, a second X ray examination was recently performed and the calculus was reported as definitely enlarged. In spite of this my opinion was indirectly sought as to whether there was not still a hope that the Chinese could fulfil his promise. To while away the time of waiting the patient first mentioned attempted to estimate the amount of fees collected per day. One woman was paying £4 17s. 6d. per week for herbs and a probable estimate of the total takings was about £100 a day. Yet our hospital's starve for funds! I visit a building worth about £15,000 owned by this Chinese, whose sincerity can best be judged by the fact that on illness in his own family flies to a medical practitioner in his neighbourhood! In the eradication of such pests our reputedly benevolent profession has failed in its protective benevolence, as far as the public is concerned. Admittedly the public in its ignorance does not appear to desire our benevolence in this direction. Suppliant methods will be of no avail and if no other measures can be adopted, let us as a corporate body stand for our rights. And if the Government demands of us the favour of a national insurance, let a basic condition be that this blight be eradicated from the community.

Yours, etc.,

June 4, 1927.

GENERAL PRACTITIONER.

HERNIA.

SIR: IN THE MEDICAL JOURNAL OF AUSTRALIA, June 11, 1927, page 861, the reviewer on passing judgement on the monograph by E. M. Cowell "Hernia and Hernioplasty" says: "Upon the establishment of this principle"—namely the existence of a congenital sac—"depends the nature of the operation and the elaborate description of various ingenious plastic operations serves no useful purpose."

The only reliable criterion for estimating the efficiency of "herniotomy" consists in the actual examination of patients at stated postoperative intervals, say at three months, at one year and at two years. Where this has been carried out the disquieting fact arises that the recurrence rate is still high, ranging in the case of indirect hernia from 3% to 10% and in direct variety from 10% to 26%.

In the case of children it is generally conceded that if the neck of a recent indirect sac be efficiently dealt with a permanent cure results. Coley's analysis of cases of simple indirect inguinal hernia indicates that, whilst the results in children are uniformly excellent, "no recurrences in two hundred and eighty-five follow-ups," in adults the results are far from satisfactory, "twenty-nine recurrences in three hundred and fifty-five follow-ups = 8.6%."

If the "saccular" theory be admitted with regard to indirect inguinal hernia, everything being equal, the same principle which guided us in the operative treatment in children should give equally good results in adults.

A perusal of the operation lists of the various metropolitan hospitals shows that "radical cure recurrent—left or right—inguinal hernia" is well to the fore, whilst in connexion with those of the Children's Hospital it is conspicuous by its absence. It is an open question whether the accessory factor, militating against a radical cure of indirect inguinal hernia in adults, originates from an accompanying weakness of the muscles or from defects in the transverse fascia.

Most surgeons recognize the futility of the usual technique for indirect hernia when applied to the direct type and various modifications of recognized procedures have been devised to correct the inherent anatomical defects giving rise to this form of rupture.

Direct hernias constitute about 10% of all primary inguinal hernias. On the other hand, approximately 50% of secondary or recurrent inguinal hernias are of this variety. This large proportion of direct recurrences indicates either that the usual operation for this type of hernia is inadequate or that the primary hernia existed as a combined direct and indirect hernia and that the direct portion of the sac was overlooked or the cases themselves were improperly selected.

Cowell's operation aims at reinforcing a weak and relaxed transverse fascia by an oblong-fascial autotransplant taken from the external oblique aponeurosis and secured in position by living sutures.

The advantage of a neighbouring pedicled flap with its temporary superior lymphatic circulation is more than counterbalanced by the reduction in the strength of the abdominal wall.

Although complete removal of the sac is the most important step in the operative treatment of any form of hernia, it is necessary in order to prevent recurrence to provide efficient support at any weakened area in the abdominal wall. The radical cure of inguinal hernia must depend upon the rectification of the various anatomical defects present and any attempt to deal with all types of inguinal hernia by a standardized operation is certainly to be deprecated.

Yours, etc.,

H. C. RUTHERFORD DARLING.

229, Macquarie Street, Sydney, June 13, 1927.

SNAKE BITE.

Sir: Dr. MacInnes's letter pointing out the futility of scarification and rubbing in of potassium permanganate at the site of the bite and the reliance on a tourniquet which is to be released cautiously at intervals to produce immunity, is of interest. As one who carried on a country practice for some years, I had to deal with several cases of snake bite or reputed snake bite and had no deaths. It appeared to me that local treatment was of very great importance. With the site of the bite more or less scarified by the patient and his friends prior to the doctor's attendance, there should be no delay in arriving at a diagnosis and all cases should be regarded as snake bite. My method was, when the tourniquet was properly applied, to inject a solution of cocaine, such as Waite's which was readily available, about 1:25 centimetres (one-half of an inch) from the circumference of the bite and cut out an area of skin of at least 2:5 centimetres (one inch) in diameter with the subcutaneous tissue underlying it and rub in

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WE Parker May 2 potassium permanganate crystals. Like Dr. Pern I have also used potassium permanganate in solution for injection in the neighbourhood of the bite. It always appeared to me to be much better to cut away the poisoned area rather than to entirely rely on producing immunity by the cautious release of the tourniquet at intervals. One of my patients who was a farmer, presented himself at my surgery stating that he was suffering from a snake bite "over the pulse." I inspected the wrist; there was unand had simply applied a tourniquet. In this case if the poison had been injected subcutaneously in the neighbourhood of the radial artery or veins, it should have passed rapidly into the general circulation. As usual the case was treated with tourniquet, excision under cocaine for local anæsthesia and crystals of potassium permanganate were rubbed in. It is better to make an effort to remove the poisoned area and use the tourniquet rather than to rely on producing immunity by the introduction of small doses of poison at intervals.

Yours, etc.,

R. A. PARKER.

140, Sackville Street, East Kew, Victoria. June 12, 1927.

CROSSED SWORDS.

Sir: Concerning Dr. Hornabrook's letter in your issue of the fourth instant in which he suggests a prefix of crossed thermometers to the names of members "who did not go overseas." Is this a reference to "cold feet"?

I agree with the writer that the "crossed swords" prefix should not be used save in a military list. I go further; I say that it certainly is not appropriate to those who were not in the war zone even if they did take a trip to Cape Town or Southampton. A crossed knife and fork would be more appropriate.

I also agree with him that the recognition implied by the crossed swords is due to men who served in any war. I suggest further that if due at all an extra sword should be added for each added campaign.

Yours, etc.,

"THE SARGE."

June 3, 1927.

DR. R. M. Shaw, of Carinya, Main Street, Mordialloc, Victoria, writes that he has "practically complete" sets of the British Medical Journal and The Medical Journal of Australia with indices, from 1920 to 1923 inclusive. He is prepared to forward these sets to anyone desiring them on application.

Congress Motes.

RADIOLOGY.

The Annual Meeting of the American Roentgen Ray Society will be held at Montreal, Canada, on September 20 to 23, 1927. Dr. Howard-Pirie is President-elect. It has been arranged that a party of British radiologists will attend the meeting. Medical practitioners from Australia who are interested in this branch of medical science and who may be going abroad at that time, will find much to interest them if they can arrange to be at Montreal at the time of the meeting.

Dbituary.

ARTHUR FREDERICK PARKER.

We regret to announce the death of Dr. Arthur Frederick Parker which occurred at Lismore, New South Wales, on May 22, 1927.

Analytical Department.

"MILTON."

"MILTON" is a liquid hypochlorite preparation recommended for the hygienic care of the teeth, mouth, throat, nose and so forth. It is manufactured by the Milton Proprietary, Limited, of Bunhill Row, London, E.C., and is claimed by the firm to be non-poisonous and cleansing.

Two samples have been obtained in Sydney and have been analysed by our own analyst. He reports that the preparation is a concentrated solution of sodium chloride and sodium hypochlorite with small amounts of lime, sulphateand carbonate. It yields 17.75% of total solids and 1.08% of available chlorine. A trace of chlorine is derived from the chlorate. The composition of "Milton" may be represented as follows:

			Analysis Figures.	Published Formula.
Sodium	chloride		 15.2 %	 16.8 %
Sodium	hypochlorit	e	 2.1 %	 1.01%
Sodium	chlorate		 0.15%	 0.5 %
Sodium	sulphate		 0.14%	 0.14%
Sodium	carbonate		 0.1 %	 0.2 %
Calcium	chloride		 0.06%	 0.08%

Both samples analysed contained about twice as much available chlorine as indicated in the formula on the carton. It is possible that the preparation intended for export overseas is somewhat stronger on account of the possible reduction of the hypochlorite in warm climates. The fault, however, is not serious, since the amount of available chlorine enhances the disinfectant power and is still not excessive. It is stated that the hypochlorite is produced by electrolysing sodium chloride and that samples analysed after two years have proved to be the same as fresh samples (Martindale). It is recommended by Victor Bonney, Blair Bell and C. W. Rundle for gynæcological purposes.

The result of our analyses and the independent reports on its therapeutic and hygienic uses justify us in concluding that "Milton" is a useful deodorizer, preservative, antiseptic and cleansing agent. The directions given on the label should be followed.

Proceedings of the Australian Medical Boards.

NEW SOUTH WALES.

THE undermentioned have been registered under the provisions of *The Medical Act* 1912 and 1915 of New South Wales, as duly qualified medical practitioners:

Bretherton, Reginald Victor, M.B., B.S., 1925 (Univ. Melbourne), 225, Miller Street, North Sydney.

Erby, Arthur Brian, M.B., Ch.M., 1927 (Univ. Sydney), Balmain Hospital.

Fargie, Eric Ian, M.B., B.S., 1924 (Univ. Melbourne). c.o. Dr. Weaver, Junee.

For additional registration:

Jeremy, Richmond, M.R.C.P. (London), 1926.

Grey, Francis Temple, Ch.M., 1925 (Univ. Sydney), 86, Harley Street, London.

VICTORIA.

THE undermentioned have been registered under the provisions of Part I. of the *Medical Act* 1915 of Victoria, as duly qualified medical practitioners:

Pannell, William James, M.B., B.S., 1925 (Univ. Melbourne), Children's Hospital, West Perth, Western Australia.

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ter, Albert Harding, L.R.C.P. et S. (Edinburgh), L.F.P.S. (Glasgow), 1894; Korong Vale.

Additional diplomas registered:

Moore, William Harold James, M.S. (Melbourne), 1927. Rosenthal, David Braham, M.D. (Melbourne), 1927.

Books Received.

A DOCTOR'S VIEWS ON LIFE, by William J. Robinson, M.D.; Edited with a biographical introduction by Eden and Cedar Paul; 1927. London: George Allen and Unwin, Limited. Royal 8vo., pp. 526. Price: 16s. net.

M.D., Sc.D., LLC., F.R.S. (Edinburgh); 1926. St. Louis: The C. V. Mosby Company; Melbourne: Stirling and Company. Royal 8vo., pp. 207, with illustrations. Price: \$2.25 net.

EXAMINATION OF CHILDREN BY CLINICAL AND LABORATORY METHODS, by Abraham Levinson, B.S., M.D.; Second Edition; 1927. St. Louis: The C. V. Mosby Company; Melbourne: Stirling and Company. Imp. 8vo., pp. 192, with illustrations. Price: \$3.50 net.

pp. 192, with illustrations. Price: \$3.50 net.

SHOULD WE BE VACCINATED? A SURVEY OF THE CONTROVERSY IN ITS HISTORICAL AND SCIENTIFIC ASPECTS, by Bernhard J. Stern; 1927. New York: Harper and Brothers. Post 8vo., pp. 146. Price: \$1.50 net.

DISEASES OF THE DIGESTIVE ORGANS, WITH SPECIAL REFERENCE TO THEIR DIAGNOSIS AND TREATMENT, by Charles D. Aaron, Sc.D., M.D., F.A.C.P.; Fourth Edition, thoroughly revised; 1927. Philadelphia: Lea and Febiger. Royal 8vo., pp. 927, with illustrations. Price: \$11.00 net.

CATECHISM SERIES: ANATOMY, Part VI; Fourth Edition; 1927. Edinburgh: E. and S. Livingstone. Crown 8vo., pp. 89. Price; 18. 6d. net.

CATECHISM SERIES: PHYSICS, Part II; Third Edition; 1927. Edinburgh: E. and S. Livingstone. Crown 8vo., pp. 68. Price: 1s. 6d. net.

Diary for the Month.

June 28.—New South Wales Branch, B.M.A.: Medical Politics Committee. June 28.—Illawarra Suburbs Medical Association, New South Wales. Wales.

UNE 30.—New South Wales Branch, B.M.A.: Branch.

JUNE 30.—South Australian Branch, B.M.A.: Branch.

JULY 1.—Queensland Branch, B.M.A.: Branch.

JULY 5.—Tasmanian Branch, B.M.A.: Council.

JULY 5.—New South Wales Branch, B.M.A.: Council.

JULY 6.—Victorian Branch, B.M.A.: Branch.

JULY 6.—Western Australian Branch, B.M.A.: Council.

JULY 7.—South Australian Branch, B.M.A.: Council.

JULY 7.—Section of Orthopædics, New South Wales Branch,

B.M.A.

JULY 8.—Queensland Branch, B.M.A.: Council.

JULY 12.—Tasmanian Branch, B.M.A.: Branch.

Medical Appointments.

Dr. Austin L'Estrange Mahon has been appointed Government Medical Officer at Tully, Queensland.

Dr. George Percival Stanley (B.M.A.) has been appointed Government Medical Officer at Tamworth, New South

Dr. James Fox Barnard (B.M.A.) has been appointed Government Medical Officer at Corowa, New South Wales.

Dr. Henry Dawson Ashton (B.M.A.) has been appointed a Medical Officer, Department of Mental Hospitals, New South Wales.

Dr. Clifford Henry (B.M.A.) has been appointed Senior Medical Officer, Department of Mental Hospitals, New South Wales.

Dr. H. R. G. Barrett (B.M.A.) has been appointed permanent Second Assistant Medical Superintendent, Mental Hospital, Goodna, Queensland.

Medical Appointments: Important Motice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

BRANCH.	APPOINTMENTS.
New South Wales: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney.	Australian Natives' Association. Ashfield and District Friendly Societies Dispensary. Balmain United Friendly Societies Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary Manchester United Oddfellows' Medica Institute, Elizabeth Street, Sydney Marrickville United Friendly Societies Dispensary. North Sydney United Friendly Societies People's Prudential Benefit Society. Phænix Mutual Provident Society.
VICTORIAN : Honorary Secretary, Medical Society Hall, East Melbourne.	All Institutes or Medical Dispensaries Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association. Hospital or other appointments outside Victoria.
QUEENSLAND: Hon- orary Secretary, B.M.A. Hullding, Adelaide Street, Brisbane.	Members accepting appointments as medical officers of country hospitals in Queensland are advised to submit a copy of their agreement to the Council before signing. Brisbane United Friendly Society Institute. Stannary Hills Hospital.
South Australian: Secretary, 207, North Terrace, Adelaide.	All Contract Practice Appointments in South Australia. Booleroo Centre Medical Club.
WESTERN AUSTRALIAN: Honorary Secretary, 65, Saint George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND (WELLINGTON DIVI- SION): Honorary Secretary, Welling- ton.	Friendly Society Lodges, Wellington, New Zealand.

Medical practitioners are requested not to apply for appointments to positions at the Hobart General Hospital, Tasmania, without first having communicated with the Editor of THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales.

Editorial Motices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to "The Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House Seamer Street, Glebe, Sydney. (Telephones: MW 2651-2.)

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INDEX TO VOLUME I., 1927.

JANUARY TO JUNE.

P	age.
A	
Agron Isaac	147
Abbott, G. H	317
Berkeley Moyninan (rev.)	124
Brodie's	99 99
Abstract, Special [see Special Abstract].	
Abstracts from Current Medical	
Authors— Abbott, Leroy C	585
Abt. I. A. and Strauss	584
Adams, Mary and Addison	797
Addis, T., Mackay and Mackay	347
Addison, W. H. F. and Adams	797
Adie, W. J	415
Adler, L	414
Akana, Walter I., Greeley and	004
Farr	100
Alger, E. M	198
Armour D	904
Addison, W. H. F. and Adams Adie, W. J. Adler, L. Akana, Walter I., Greeley and Farr Alger, E. M. Anschütz, W. Armour, D. Armstrong, E. L. and Scammon	001
mon	310
Bardachzi, Franz	761
Barney, J. D	727
Bartlett, W. M	584
Bassier, A	219
Book H C	654
Bendick A I and Rubin	760
Benjamins, C. E.	198
Bennett, M. A	347
Benson, W. T. and Simpson	866
Bentel, G. P	726
Bernard, E. and Lemierre	94
Armstrong, E. L. and Scammon Bardachzi, Franz Barney, J. D. Bartlett, W. M. Bassler, A. Bean, R. Bennett Beck, H. G. Bendick, A. J. and Rubin Benjamins, C. E. Bennett, M. A. Benson, W. T. and Simpson Bentel, G. P. Bernard, E. and Lemierre Besley, F. A. Best, C. H., Dale, Dudley and Thorpe	905
Thomas Thomas	099
Rinet I.	246
Blackfan K D	128
Bodnar, L	414
Thorpe Binet, L. Blackfan, K. D. Bodnar, L. Boemingham, H. and Pollak Bourgeois, Chevalier, Georges and Levy-Bruhl	163
Bourgeois, Chevalier, Georges	
and Levy-Bruhl	866
Boyden, Ruth and Okey	833
Brain, W. Russell	61
Brams, William A. and Meyer	380
Brown Alfred	190
Burrell L S T	867
Cadenat. F. M.	905
Cameron, A. T 95	550
Carman, R. D. and Moore	760
Bourgeois, Chevalier, Georges and Levy-Bruhl Boyden, Ruth and Okey. Brain, W. Russell Brams, William A. and Meyer Brennemann, J. Brown, Alfred Burrell, L. S. T. Cadenat, F. M. Cameron, A. T	347
Carwardine, T	26
Cekada, E. B. and Howell	346
Chamberlain, Digby	381
Chenge Lenthal	26
Chamberlain, Digby Cheatle, George Lenthal Cheney, W. F. Chesney, Alan M., Kemp and	95
Poole Kemp and	246
Poole Chevalier, Levy-Bruhl, Georges	210
and Doumenate	000

F	age.
bstracts from Current Medical Literature—Continued.	
Literature—Continued.	
Authors—Continued. Christensen, H. H. and Smith Christie, A. C. Clark-Kennedy, A. E. and	
Christensen H H and Smith	27
Christia A C	381
Clark Kannada A F and	901
Clark-Kennedy, A. E. and	040
Owen	340
Colby, W	991
Clark-Kennedy, A. E. and Owen Colby, W	61
Comrie, John D. and Dawson	415
Cooke, J. V	278
Coombs, H. I. and Stephenson	833
Corbett, Rupert S. and Pierce	380
Cotton T F	162
Cotton, T. F	
Wilson	61
Compie D M	550
Cowrie, D. M	600
Craig, Charles F 246	, 094
Crile, Denis	129
Crocket, J	654
Cronin, A. J	247
Dale, H. H., Best, Dudley and	
Thorpe	832
Dandy Walter E	380
Danhnov C C and Zilva	833
Daubley, C. G. and Zirva	415
Dawson, J. W. and Comrie	410
Dekeyser, L., Francis and	201
Halkin	761
Dévé F	761
Dickson, Frank D	585
De Jong, H	61
Dorne, M	163
Dourmashkin, R. A	727
Drevfus, G. L. and Hanau	34
Halkin Dévé F. Dickson, Frank D. De Jong, H. Dorne, M. Dourmashkin, R. A. Dreyfus, G. L. and Hanau Dubrenilh, Suzanne and Parmenter	
montor	247
Dudgeon I C	162
menter Dudgeon, L. S. Dudley, H. W., Best, Dale and	102
Dudley, H. W., Best, Dale and	000
Thorpe Duke-Elder, W. S	, 832
Eadie, G. S	833
Einhorn, M	380
Evans C Loyatt	833
E Ch	005
Farr, Charles E	905
Akana and Greeley	381
Fifield, L. R	866
Fisher, A	866
Floyd, M. L. and Jeans	94
Forbes, A. Mackenzie	129
Fouts, R. W	760
Francis, P., Dekeyser and	
Halkin	761
Freiligh E and Lewison	867
Frobisher, M. and Leonard	$867 \\ 727$
Fronisher, M. and Leonard	210
Fry, H. J. and Shattock Fry, H. J. B. and Swan	310
Fry, H. J. B. and Swan	
Galewsky, G	278
and Bourgeois	866
Gottlieb. J.	163
Gran E	867
Cray A M U	970
Gray, A. M. H	418
Greeley, Horace, Junior,	
and Bourgeois Gottlieb, J. Grau, E. Gray, A. M. H. Greeley, Horace, Junior, Akana and Farr	381
Grier, G. W	761
Griffiths, S. J. H.	381
Grier, G. W	198
	400

	Page.
bstracts from Current Medica Literature—Continued.	1
Anthony Continued	
Gwyn, N. B	. 550
Hadjidakis, G. E	. 414
Halban, J	655
Halkin, Francis and Dekeyse	r 761
Hamburger, C	. 618
Hamburger, C	. 311
Harding, Maynard C.	. 584
Harbin, R. M	. 832
TT T C NE CO	.7
Mann Harrison, Guy R. Harrower, H. R. Hauge, S. M. and Carrick Hare, H. A. Henschen, S. E. Hess, A. F., Weinstock an	. 94
Harrison, Guy R	654
Hange S M and Carrick	347
Hare, H. A.	. 905
Henschen, S. E	. 61
Hess, A. F., Weinstock and	d
Sherman	. 584
Hicks C S	832
Sherman	. 346
Higgins, G. M. and Mann Hinman, F. And Vecki Hochenblichler, A. Holmes, G. W. Hornung, E. S. Hossack, J. C. Howell, W. H. and Cekada	. 727
And Vecki	. 163
Hochenblichler, A	. 60
Holmes, G. W	. 760
Hossack, J. C	654
Hossack, J. C	. 346
Hunter, C	. 867
Hunter, C	. 797
Husik, David N. Izume, Seiichi and Lewis Jackson, A. S. Jameson, P. C. Jeans, P. C. and Floyd Jenkins, G. J. Jepson, Paul N. Jones, Isaac H. and Knudser Kaiser, Albert D. Kantor, J. L. Kemp, Jarold E., Chesney and	247
Jackson, A. S	. 904
Jameson, P. C	. 198
Jeans, P. C. and Floyd	. 94
Jenkins, G. J	. 619
Jones Isaac H and Knudser	n 619
Kaiser, Albert D	. 199
Kantor, J. L	. 279
Kemp, Jarold E., Chesney and	d
Poole	693
Killick, E. M. and Mellanb	v 833
Knudsen, Vern O. and Jone	s 619
Poole	. 692
Krans W M. and Silver	-
man	. 655
Küstner H	. 414
Lambert, R. A. and Mever .	. 692
Lambert, R. A. and Meyer . Lane, C. W., Weiss and Show	-
man	. 726
Larsell, U	796
Legg. Arthur T.	. 585
Lemierre, A. and Bernard .	. 94
Lemoine, M	905
Lent, E. J. and Lyon	. 618
Lane, C. W., Weiss and Show man Larsell, O	727
Leriche, R. and Policard .	. 26

Abst

Hy I

Abstracts from Current Medical Literature—Continued.
Authors-Continued.
Levy-Bruhl, Chevalier, Georges and Bourgeois 866
and Bourgeois 866
Levy, Gabrielle and Roussy. 655 Levy, Leonard A. and West . 761
Lewis, T. and Harmer 832
Lewison, M. and French 550
Luscinian, J. H 279
Lewis, Howard B. and 12ume 341 Lewis, T. and Harmer 832 Lewison, M. and Freilich 867 Lieb, C. W 550 Luscinian, J. H 279 Lyon, M. B. and Lent 618 MacCready, Paul B 619 Macdonald, A. D. and Schlapp 346 MacErlean, D. A 94
MacCready, Paul B 619
MacErlean, D. A 94
MacErlean, D. A 94 Macgruder, L. F 279 MacKay, E. M. and L. L. and
MacKay, E. M. and L. L. and
Addis 347
706
Maloney, E. R 726
Manges, W. F 279
Mallory, F. B. and Stewart
Mann, S. A., McCowan and
Marchionini, A 727
Marinesco, G 415
Marris 94 Marchionini, A 727 Marinesco, G 415 McCowan, P. K., Harris and
McCowan, P. K., Harris and Mann
McNealy, R. W 27
Medlar, E. M 310
Mellerby M and Killick 833
Metzger. E 866
Meyer, J. R. and Lambert 692
Meyer, Karl A. and Brams 380
Meyer, K. T 279 Michaeloff, Alexander 246 Michaeloff, Alexander
Milch, Henry
Milligan, William 199
Miyake, Koichi 415
Moore A B and Carman 760
Motta, Cunha 796
Montenegro, J
Murples, E., Throne, van Dyck and Myers 278 Murrell, Christine M 693
Murrell, Christine M 693
Myers C. N., Throne, van
Dyck and Murples 218
Neri, Vincenzo
Norton, R. C. and Shohl 128
O'Hara, D 551
O'Hara, D
Parker, Harry L. 380 Parmenter, Derric C. and 247 Dubrenilh 247 Pascheff, C. 618
Dubrenilh 247
Pascheff, C 618
Pedlev. Frank G 933
Percival, G. H. and Stewart 726 Pierce, Carleton B. and Cor-
bett 380
Policard, A. and Leriche 26
Tollar, W. and Dooming
Poole, Allan K., Kemp and Chesney 246
Porter. A
Poston, Richard Irvine 655
Quick, Douglas 278
Ramage, Ronald 797 Reynolds, F. Esmond and
Turner 199
Riddell, James and Wilson 310
Robb, J. J
Robinson, Samuel 27 Rolleston, Humphry 551

Abstracts from Current Medical Literature—Continued.	
Anthors-Continued	
Rollier, A 1	2
Rollier, A	4
Rothschild, A	Z
Roussy, Gustave and Levy Roxburgh, A. C	9
Rubin I C and Bendick 7	6
Russell, R. Hamilton	2
Ryan, E. J. and Stewart 7	6
Sampson, John A	6
Sawyer, William Alfred and	
Slater	4
Scammon, R. E. and Arm-	4
strong	-
Schall, Le Roi A	6:
Schild. E. H 6	11
Schlapp, W. and Macdonald 3	4
Schohl, A. T. and Norton 1	28
Scott, J. A 7	2(
Shaffer, L. W. and Weidman 2	78
Shahan, W. E 6.	18
Shaw M E and Symonds A	11
Shaw Wilfred 60 4	14
Shellshear, J. L	97
Sherman, E., Hess and Wein-	
stock 58 Showman, W. A., Weiss and	84
Showman, W. A., Weiss and	
Lane	26
Silverman, N. E. and Kraus 6	55
Simpson, G. W. and Benson. 86	bt
Slater, Benjamin J. and	17
Sawyer	17
Smith, J. F. and Christensen	27
Smith, J. F. and Christensen Spaeth, E. D	8
Spirina, A. and Korschun 69	12
Starling, E. H. and Visscher 83	32
Stenstrom, Bo 79	16
Stephenson, M. and Coombs 83	3
Stephenson, M. and Coombs. 38 Sternberg, H	0
Stewart, C. P. and Percival 72	0
Stewart F W and Mallory 79	B
Stewart, W. H. and Ryan 76	0
Stockman, Ralph 79	6
Strauss, A. A. and Abt 58	4
Swan, R. H. Jocelyn and Fry 31	0
Symonds, C. P. and Shaw 41	5
Taylor, James 65	5
Thorpe, W. V., Best, Dale and	
Dudley 83	2
Dudley 83 Throne, B., van Dyck, Murples	_
and Myers 27	8
Tilmann, E.	0
Turner, A. Logan and	
Reynolds 19	9
Upson, W. O 76	0
van Dyck, L. S., Throne, Murples and Myers 27	
Murples and Myers 27	8
Vecki, M. and Hinman 16	3
Vecki, M. and Hinman 16 Verhoeff, F. H 61	
Vignati, J	2
Visscher, M. B. and Starling 83	2
Walther, H. W. E 163	2
Walther, H. W. E 16: Warwick, B. L 31	
Watson, H. Ferguson 65	
Weidman, F. D. and Shaffer 278 Weinstock, M., Hess and	ð
Shorman 58	4
Weiss, R. S., Lane and Show-	*
man 720	6
West, Donald W. and Levy 76	1
West, W. K 58	5
Whitaker, Joel 618	8

Abstracts from Current Medical Literature—Continued.
Authors—Continued.
Whitehouse, Beckwith 60
Wile, V. J
Wilson, W. Cheyne and Rid-
dell 310
dell
Bacteriology and Immun-
ology 246, 692
ology
Entamoba Histolatica 692
Cultivation of 692 Method of Cultivating 246 Leishmaniasis, Diagnosis of, by Skin Reaction 692 Ozæna Fætida, The Causal Organism in 246 Plasma, The Use of, in Com-
Leishmaniasis, Diagnosis of,
Ozena Fortida The Causal
Organism in
Plasma, The Use of, in Com-
Pneumococcus, Immunity to
the 246
Syphilis, Experimental 246
Pneumococcus, Immunity to the
Antiscorbutic Fraction of
Blood, Acidity of 333
Calcification in Rabbits 833
Microorganisms 01
Hydrazine and Metabolism 347
Kidney, The, and a Diet Con-
taining Excess of Protein and Cystin
Lactic Acid Formation 833
Metabolism in Menstruation 833 Starch, Hydrolysis of, by
Amylase 833 Vitamin, Antineuritic 347
Dormoteless
Dermatology 278,726 Acne Agminata: A True Skin
Tuberculogie 798
Calcification of the Skin In- cluding the Epiderm in Con-
nexion with Extensive Bone
Absorption
Chronica Helicis 726
From Emetin
Infants
logical Factor in
ichthyosis, Basal Metabolism
Oldiomycosis of the Nails 726
Pityriasis Rosea 726
Ultra-Violet Light in Urology 726
Gynæcology and Obstetrics 60, 414
Abortion, Treatment of 60
Mensiruation
Embolism, Post Partum Pul-
Granfian Politicle in the Hu-
Hæmorrhage, Uterine, Causa-
tion and Treatment of 414
metriosis 60

Page,

Abstracts from Current Medical Literature—Continued. Gynæcology and Obstetrics— Continued. Ovary, The Interstitial Cells of the Human	Page.
Overy, The Interstitial Cells of the Human Puerperal Infections, Streptococcal Virulence in	Abstracts from Current Medical
Ovary, The Interstitial Cells of the Human 60 Puerperal Infections, Streptococcal Virulence in 414 Puerperal Sepsis, Post Mortem Findings in 414 Retention of Urine, Postoperative 414 Salpingitis and Perimetritis, Treatment of 414 Hygiene 247, 693 Benzol Poisoning 693 Dust Inhalation by Hematite Miners 247 Married Woman Worker, The 693 School Teacher, The Health of the 247 Silicosis, Experimental 693 Skin Diseases in an Industrial Clinic 247 Tin and Its Salts, Chronic Poisoning by 693 Laryngology and Otology 198, 618 Counter-Rolling of the Human Eye, The 198 Ear Disease, Hæmorrhagic Types of, Occurring During Epidemics of Influenza 199 Hæmatoma of the Soft Tissues of the Throat 199 Infection, Paths of, to the Brain, Meninges and Venous Blood Sinuses 199 Meningitis, Cystic Serous 619 Middle Ear Suppuration in Children 199 Aracusis 619 Thymic Death in an Adult 618 Tonsillectomy in Children 199 Sinusitis and Maxillary Cysts, Iodized Oil as an Aid in the Diagnosis of 619 Medicine 94,550,866 Achlorhydria, Significance of 95 Asthma, Bronchial and Tuberculosis 867 Bacteriophage, The 550 Blood— Letting 94,550,866 Achlorhydria, Significance of 95 Asthma, Bronchial and Tuberculosis 867 Bacteriophage, The 550 Blood— Letting 94,550,866 Achlorhydria, Significance of 95 Asthma, Bronchial and Tuberculosis 867 Bacteriophage, The 550 Cholera Infantum, Upper Respiratory Infections as a Cause of 94 Pressure, High 551 Bronchiectasis 867 Bacteriophage, The 550 Cholera Infantum, Upper Respiratory Infections as a Cause of 94 Pribrosities 867 Gout, The Differential Diagnosis of 94 Pribrosities 866 Encephalitis Lethargica, Blood Sugar Studies in 94 Pribrosities 867 Gout, The Differential Diagnosis of 550 Meningitis, Septic, Treatment of	Gynæcology and Obstetrics—
of the Human Puerperal Infections, Streptococcal Virulence in	Continuea.
tococcal Virulence in	of the Human 60
Puerperal Sepsis, Post Mortem Findings in	tococcal Virulence in 414
Salpingitis and Perimetritis, Treatment of	Puerperal Sepsis, Post Mor-
Salpingitis and Perimetritis, Treatment of	Retention of Urine, Post-
Benzol Poisoning	operative 414
Benzol Poisoning	Treatment of 414
Dust Inhalation by Hematite Miners	Hygiene
tite Miners	Benzol Polsoning
School Teacher, The Health of the	tite Miners 247
silicosis, Experimental	
Silicosis, Experimental	
Skin Diseases in an Industrial Clinic	Silicosis, Experimental 693
Syphilis in Industry Tin and Its Salts, Chronic Poisoning by	Skin Diseases in an Indus-
Tin and Its Salts, Chronic Poisoning by	
Laryngology and Otology . 198, 618 Counter-Rolling of the Human Eye, The	
Counter-Rolling of the Human Eye, The	
Eye, The	Laryngology and Otology 198, 618
Ear Disease, Hæmorrhagic Types of, Occurring During Epidemics of Influenza 199 Hæmatoma of the Soft Tissues of the Throat 199 Infection, Paths of, to the Brain, Meninges and Venous Blood Sinuses 199 Meningitis, Cystic Serous 619 Middle Ear Suppuration in Children 198 Paracusis 619 Thymic Death in an Adult 618 Tonsillectomy in Children 199 Sinusitis and Maxillary Cysts, Iodized Oil as an Aid in the Diagnosis of 619 Medicine 94,550, 866 Achlorhydria, Significance of 94 Asthma, Bronchial and Tuberculosis 867 Bacteriophage, The 550 Blood— Letting 94 Pressure, High 550 Bronchiectasis 867 Calcium— Biochemistry of 95 Metabolism 550 Cholera Infantum, Upper Respiratory Infections as a Cause of 94 Diverticulitis 866 Encephalitis Lethargica, Blood Sugar Studies in 94 Diverticulitis 866 Encephalitis Lethargica, Blood Sugar Studies in 94 Diverticulitis 866 Encephalitis Lethargica, Blood Sugar Studies in 94 Diverticulitis 866 Encephalitis Lethargica, Blood Sugar Studies in 94 Meat Diet, The Effects of an Exclusive and Long-Continued 550 Meningitis, Septic, Treatment of 550 Meningitis, Septic, Treatment of 550 Meningitis, Septic, Treatment of 550	
Epidemics of Influenza . 199 Hæmatoma of the Soft Tissues of the Throat	Ear Disease, Hæmorrhagic
of the Throat	Epidemics of Influenza 199
Brain, Meninges and Venous Blood Sinuses	Hamatoma of the Soft Tissues
Brain, Meninges and Venous Blood Sinuses	Infection, Paths of, to the
Meningitis, Cystic Serous Middle Ear Suppuration in Children	Brain, Meninges and Venous
Paracusis	Meningitis, Cystic Serous 619
Thymic Death in an Adult 618 Tonsillectomy in Children 199 Sinusitis and Maxillary Cysts, Iodized Oil as an Aid in the Diagnosis of 619 Medicine 94,550,866 Achlorhydria, Significance of 95 Asthma, Bronchial and Tuberculosis 867 Bacteriophage, The 550 Blood— Letting 94 Pressure, High 551 Bronchiectasis 867 Calcium— Biochemistry of 95 Metabolism 550 Cholera Infantum, Upper Respiratory Infections as a Cause of 94 Diverticulitis 866 Encephalitis Lethargica, Blood Sugar Studies in 94 Epilepsy, Ætiology of 550 Fibrositis 867 Gout, The Differential Diagnosis of 94 Meat Diet, The Effects of an Exclusive and Long-Continued 550 Meningitis, Septic, Treatment of 560 Pulmonary Complications,	Middle Ear Suppuration in
Iodized Oil as an Aid in the Diagnosis of 619 Medicine	Paracusis 619
Iodized Oil as an Aid in the Diagnosis of 619 Medicine	Thymic Death in an Adult 618 Tonsillectomy in Children 199
Medicine 94,550, 866 Achlorhydria, Significance of 95 Asthma, Bronchial and Tuber- culosis	Sinusitis and Maxillary Cysts,
Medicine 94, 550, 866 Achlorhydria, Significance of 95 Asthma, Bronchial and Tuber- culosis 867 Bacteriophage, The 550 Blood— Letting 94 Pressure, High 551 Bronchiectasis 867 Calcium— Biochemistry of 95 Metabolism 550 Cholera Infantum, Upper Respiratory Infections as a Cause of 94 Diverticulitis 866 Encephalitis Lethargica, Blood Sugar Studies in 94 Epilepsy, Ætiology of 550 Fibrositis 867 Gout, The Differential Diagnosis of 94 Meat Diet, The Effects of an Exclusive and Long-Continued 550 Meningitis, Septic, Treatment of 560 Pulmonary Complications,	the Diagnosis of 619
Achlorhydria, Significance of Asthma, Bronchial and Tuberculosis	
culosis	Achlorhydria, Significance of 95
Bacteriophage, The 550	Asthma, Bronchiai and Tuber-
Letting 94 Pressure, High 551 Bronchectasis 567 Calcium— Biochemistry of 95 Metabolism 550 Cholera Infantum, Upper Respiratory Infections as a Cause of 94 Diverticulitis 866 Encephalitis Lethargica, Blood Sugar Studies in 94 Epilepsy, Ætiology of 550 Fibrositis 867 Gout, The Differential Diagnosis of 867 Hepatic Extract 94 Meat Diet, The Effects of an Exclusive and Long-Continued 550 Meningitis, Septic, Treatment of 866 Pulmonary Complications,	Bacteriophage, The 550
Pressure, High 551 Bronchiectasis	Tottler at 04
Calcium— Biochemistry of	Pressure, High 551
Metabolism	Dioneniectasis out
Respiratory Infections as a Cause of	Biochemistry of 95
Respiratory Infections as a Cause of	Cholera Infantum, Upper
Diverticulitis	Respiratory Infections as
Sugar Studies in	Diverticulitis 866
Epilepsy, Ætiology of	Encephalitis Lethargica, Blood
Gout, The Differential Diagnosis of	Epilepsy, Ætiology of 550
nosis of	Gout. The Differential Diag-
tinued	nosis of 867
tinued	Meat Diet. The Effects of an
Meningitis, Septic, Treatment of	Taxcidate and Dong-Con-
Pulmonary Complications,	Meningitis, Septic. Treatment
Postoperative 550	of
	Postoperative 550

_	
Abstracts from Current Medical Literature—Continued.	age.
Medicine—Continued.	
Purpura of Gonococcal Origin,	000
Scarlet Fever	866
Control of, in Institutions	551
Generalized	551
Sclerosis—	
Disseminated, Early Signs of	866
of	94
Spinal Cord, Subacute Com- bined Degeneration of the	94
Morbid Anatomy 310,	796
Fibro-sarcoma of the Uterus.	
Two Types of Giant Cell in Hæmatoma, Ossifying, of the	796
Femur	310
Femur	796
Cord	796
Muscle, Degenerative Changes	
in Skeletal Sarcomatous Permeation of	796
the Vena Cava	310
Spondylitis, Ossifying	
Tuberculosis—	
Giant Cells in Of the Male Breast	$\frac{310}{310}$
Manushalama 210	707
Arteries of the Brain of the	
Orang-Utan, The	797
Arteries of the Brain of the Orang-Utan, The Blood Supply, The, to the Peripheral Nerves of the Superior Extremity	
Superior Extremity	797
Duodenum, The Development	
of the Eyeball, Human, and Optic	797
Nerve, on the Growth of	310
Hypophysis in the Albino Rat	797
Mitochondria Ova, Intrauterine, Migration	797
Ova, Intrauterine, Migration of	311
Races of Man, Types of Three	311
Sympathetic Trunks, The	
Rôle of Cells of Medullary Origin in the Development	
of the	311
of the	
of the Central Nervous	
System	311
Neurology 61, 415,	655
Cerebral Disorders After Wounds of the Cervical	
Cerebral Disorders After Wounds of the Cervical Sympathetic	415
Tendon Jerks	415
Dementia Præcox, Infantile Encephalitis, Vestibular or	655
Labyrinthine	655
Family Disease, Seven Cases of a Special	655
Inganity in Japan	415
ease Sui Generis	415
Paresis, Facial, in Spinal	655
Posture of the Head, Rotated	
or Cerebellar Psychiatry, Progress in	61 61

Abstracts from Council Maddell	age.
Abstracts from Current Medical Literature—Continued.	
Neurology—Continued	
Right Hemisphere of the Brain in Relation to the Left Sclerosis—	61
Amyotrophic Lateral 61 Syphilis and Mental Disease	415
Disseminated 61 Synhilis and Mental Disease	655
Syringomyelia with Nerve	000
Syringomyelia with Nerve Root Cavities	415 61
Ophthalmology 198	, 618
Ophthalmology 198 Circulation, The Ocular Cornea, A Conjunctival Flap	198
for Wound of the	198
Pseudohallucinations After	618
Fusion Impulse, Suspension of the, as a Therapeutic Measure	400
Glaucoma, Treatment of, with "Glaucosan" and "Amine- Glaucosan"	
Glaucosan"	618
Lagrange Operation Modified	618
Prism Test for Panophthalmitis, Sympathetic	618
Graft Operation for	198
Pterygium, Rotated Island Graft Operation for Uveitis Sympathetic, Diph- theria Antitoxin for	610
Orthopedic Surgery 129	010
Orthopædic Surgery 129, Contracture, Ischæmic	129
Coxa Plana Fracture—	585
Avulsion, of the Tuberosity	
of the Ischium Of the Os Calcis	585 584
Fractures of the Shaft of the	
Femur	585
Paralytic Hypoglosso-facial Anastomo-	585
sis for Facial Paralysis	129
Median Nerve Lesions Pott's Disease	129 129
Tensor Fasciæ Femoris, The	129
Tibia and Fibula, The Opera- tive Lengthening of the	585
Tuberculosis of the Hip Joint	129
Pædiatrics 128, Cisterna Magna, Puncture of	
the	584
of the Stools of New-Born	
Infants, The	128 128
Meckel's Diverticulum	584
Nephritis, Acute	148
Children, The Rickets and Ultra-Violet	584
Radiation	584
Physical Therapy	761
Actinotherapy— In Cutaneous Tuberculosis	761
Measurement of Dosage in Hydatid Cysts and Radio-	
therapy	761
therapy	761
Metropathy, X Ray Treat-	200
ment for	76I 832
Adrenalin Vasodilatation	346
Blood, Delayed Clotting of Hæmophilic	346

Aus

0

Au

Au

Av

Ba

7.		P	age.	- 1
Abstracts from	n Current	Medical		Abstracts
Literatu	re-Continue	d.		Lit
Physiology-C	ontinued.		040	Therap
Gall Bladd	er, Emptying	of the	832	Gono
Humour.	ergy Output The Aqueous	01 0110	832	Hear
Respirator	y Exchange	During		Нера
Exercise			346	Infec
Spleen, Th	ne Functions bulin, Secre	of the	829	Res
	r Substance		002	"Nov
lease of.	in Injuries	of the		Ch
Skin	rs from Tiss		832	Pitui
Vasodilato	rs from Tiss	ues	832	"San
Radiology .		278.	760	Pu: Syph
Aortic Re	gurgitation		760	Ultra
Carcinoma	_		000	Urology
Of the	Tongue tic, in Bone		278	Calcu
Cholecysto	graphy		760	"Coll
	graphy cerative			Inf
Foreign B	odies in the	Lung,		Dilat
Non-Opa	que Chronic in Pelvic Di	** **.	279	Hydr
"Liniodol"	in Pelvic Di	agnosis	760	"Mer
Metatarsal	Head, Impa	ction of		Con
the			279	"Neo
	Ossificans		970	Pain,
Progress Traumat	iva		760	Cai
Radiograp	hy of the Co	lon	760	Prost
Stasis, Ile	al		279	Pyelo
Surgery		26, 380,	904	Speri
Surgery Adhesions, Aneurysms	The Forma	tion of	26	int
Aneurysms	, Wiring an	d Elec-		Res
trolysis	of		905	Tumo
Bone Some	Fundament	ograde	909	Ele
	the Patho		26	. 116
Calculi, Sa	alivary		27	Acland, 1
Cancer, P	rognosis in	Rectal	905	Actinothe
Carcinoma Of the C	olon		27	Act, Work
Of the Il	eum		381	Medie Milla
Cholelithia	sis Rese	embling		Adenoma
Renal D	Disease um, Meckel's s or Osteocho		380	Aitken,
Eniphysitis	im, Meckers	ndritis	381	Alfred H
Extraperit	oneal Closu	ire of	001	The
Artificial	Anus		26	Allan, R.
Fistulæ, F	revention o ion from In	f Skin	97	Interim
Fracture	of the Tib	is and	27	Morta
*****			905	Victo Future
Gall Bladd	er Disease, R	eferred		ter C
Pain in			381	Allergy o
tality F	e Operations	, Mor-	380	Alleyne, I
- Gastric an	d Duodenal	Ulcer.	380	Alopecia
Goître, Pr	rimary Thy	reoidec-		Alvarenga
tomy for Hernia, S	Exophthaln	nic	904	American
Infant F	rangulated, live Days O	in an	381	Anæmia-
	is, Acute		381	Pernici
Ramisectio	n and Peria	arterial		By F
Sympath	ectomy in	the	005	Or Spri
Rupture of	nt of Spastic	ity	905	ley Severe,
Male. O	peration for	Tran-		Anæmias,
			905	Anæsthes:
Spinal Co	rd and its	Mem-		thetic
branes,	Surgery of t Radical Op	he	904	Ether,
for Uret	hral		26	Ethylen
Suppuratio	n, Intracran	ial	380	Leona
Sympathec	tomy, Peris	arterial		Intratra
Tumours-			200	Ether
Brain	ie		380	Nitrous W S

Pa	ıge.
Abstracts from Current Medical Literature—Continued.	ee a
Therapeutics 162, Gonorrhœa, Treatment of	162
Therapeutics 162, Gonorrhœa, Treatment of Chronic	162 654
Infections— Acute Bacterial	162
Acute Bacterial Respiratory "Novasurol" and Ammonium Chloride	654
Chloride Pituitary Lobe, Anterior "Sanocrysin" Treatment of	654
Pulmonary Tuberculosis Syphilis	654 654
Urology 162, Calculi, Ureteral "Collargol" and Urinary Tract Infections	163
"Collargol" and Urinary Tract Infections Dilator, A New Ureteral Hydronephrosis, Hæmaturia in "Mercurochrome" in Urological Conditions "Neosalvarsan" Treatment of Cystitis Pain, Abdominal, Urological Causes of	727
"Mercurochrome" in Urological	163
"Neosalvarsan" Treatment of	727
Pain, Abdominal, Urological Causes of	727
Causes of	727 163
Surface Tension of the Urine in the Application of "Hexyl-	103
in the Application of "Hexyl- Resorcinol"	727
Treatment of	$\frac{163}{726}$
Acland, H. T. D	$\frac{480}{722}$
Act, Workers' Compensation: Some Medical Aspects, by R. J.	
Millard	562 659
Aitkon W	477
Alfred Hospital Clinical Society, The	$927 \\ 451$
Interim Report on Maternal Mortality and Morbidity in	,
Victoria Future of Obstetrics, The (Lister Oration)	
Allergy of the Respiratory Tract Alleyne, Haynes Gibbes	515
Alopecia Areata	102
American Roentgen Ray Society	
Anæmia— Pernicious By Frank A. Evans	481
Or Sprue, by N. Hamilton Fair-	305 559
Severe, Heart Murmurs in Anæmias, The	689
Anæsthesia and the Newer Anæs- thetics—	
Ether, by Reginald Howden 596, Ethylene and Oxygen, by G.	62 0
Leonard Lillies 601, Intratracheal Administration of	
Ether, The, by F. W. Green 598, Nitrous Oxide and Oxygen, by W. S. Newton 599,	620
W. S. Newton 599,	620

Page.
Anæsthetics and Their Introduc- tion to Australia and Tas-
tion to Australia and Tas-
mania, An Essay Relating Chiefly to—
By Gilbert Brown 285
By Norman J. Dunlop 121.
By Gilbert Brown
Analytical Department
Kellogy's "Corn Flakes" 827
"Milton"
Anatomy—
Baillière's Synthetic: A Series
of Drawings on Transparent
Sheets for Facilitating the
Reconstruction of Mental Pic-
tures of the Human Body, by J. E. Cheeseman (rev.) 410
Short History of, A, by Richard H. Hunter (rev.)
Anderson, A. V. M 349, 658, 762
Anderson, C. C 429, 457, 459
Anderson, E. Gordon 436
Anderson, J. Kingiand 455
Anemia Pernicious by Frank A
Evans (rev.) 305
Aneurysm-
Healed Dissecting, Giving Rise to the Appearance of a Double
to the Appearance of a Double
Aorta, by J. Burton Cleland 538, 552
land 538, 552 Left Subclavian: Intrathoracic Ligature, by R. J. Wright Smith 754
Ligature, by R. J. Wright
Smith
Of the Descending Aorta 625
Angioma of the Larynx, Cavernous 868
Currence
Antenatal Clinic 200
"Anon" 735 Surgeons 840 Antenatal Clinic 200 Anthropology 660 Aortic Regurgitation, Blood Pressure in the Leg in by Fric F
Aortic Regurgitation, Blood Pres-
sure in the Leg in, by Eric F.
Gartrell
Archer H R 735
Argyle, Stanley S 445, 457, 458, 471
Argyll-Robertson Punil The A
Argyll-Robertson Pupil, The: A Contribution Towards its Ex-
planation, by Herbert J.
planation, by Herbert J. Wilkinson
Armstrong, G
Arnold F. C
Arnold, F. S
Arsenical Neuritis Treated by the
Intravenous Injections of Sodium Thiosulphate, by T.
Dixon Hughes 543
Actute, of the Hip Joint 835 Rheumatoid, Treated at Para- lana Hot Springs, South Aus-
Rheumatoid, Treated at Para-
lana Hot Springs, South Australia, by C. C. Fenton
Suppurative
Suppurative 99
ment of Acute, by Balcombe
Quick 391, 416
Quick
Arthrodesis of the Shoulder Joint 99
Arthur, Richard-
Hypnotic Suggestion 253, 627
Aspinall, Archie 735, 926 Radiotherapy 663, 875 Association [see New South Wales
Aggediation Loca Name Courth Webs
Public Medical Officers' Asso-
ciation 1
Assurance, Life, and Heart Dis-
ease
ease

Page. c-s-g

. 285 21, 21, 525

. 827 . 931 . 756

tt ee 3-y . 410 d . 826 8, 762 7, 459 . 436 . 455

. 305

e e 8, 552

515

Page.	Domo	P
	Bacteriology 159	Plackman G T 459 459
Atrophy—	Bergey's Manual of: A Key for	Blackmore, G. J 458, 459 Bladder Tumours 459
Optic	the Identification of Organ-	Blastomycosis, A Case of Systemic,
Origin 103	isms of the Class Shizomy-	With the Formation of a
	cetes, by David H. Bergey	Myxomatous Looking Tumour-
Austin, J. Harold, and Glenn E.	(rev.) 580	like Mass, by J. Burton
Cullen (Hydrogen Ion Concen-	Badham, Charles 699	Cleland 337
tration of the Blood in Health	Baldwin, A. H., G. M. Heydon and	Blood Formation 481
and Disease) (rev.) 545	J. A. Broben—	Blood Pressure, High, its Vari-
Australasian Medical Congress	Amœbic Dysentery Acquired in	ations and Control: A Manual
(British Medical Association) 24	North Queensland 374	for Practitioners, by J. F.
Finances 521, 729	Balfour, Andrew-	Halls Dally (rev.) 545
General Meeting 520	Red Back Spider Bite, The 873, 910	Bloomfield, A. L
Inaugural Meeting 427	Bannon, J 523	Boas, E. P 689
(Leading Article) 547	Barber, G. W 433, 476, 477	Bockhart's Impetigo 445
Lecture, Popular 427	Barling, J. E. V 523	Bolam, Sir Robert 591
Medical School, The, Otago 66	Barnett, Sir Louis E 875	Bone—
Meetings-	Barnett, L. E 350, 430, 449, 471,	Disease, Multiple, Causing Bi-
General 520	480, 485, 520, 521, 522	lateral Proptosis 610
Inaugural 427	Presidential Address (Austral-	Inflammation and Toxic Dis-
Sectional [see "Sectional"].	asian Medical Congress [Brit-	eases of, The: A Textbook for
Special 517	ish Medical Association]) 423, 427	Senior Students, by R. Law-
Notes 66	Barrett, Sir James 431, 441, 455,	ford Knaggs (rev.) 546
Popular Lecture 427	456, 475, 488, 665	Inflammation and Tumours of 512
President's Address, by L. E.	Consanguineous Marriages 628	Lesion of 656
Barnett	Basal Metabolism, The Gravi-	Books of Interest to Doctors 420
Resolutions of (Leading Article) 615	metric Determination of, by	Books Received 34, 104, 136,
Sectional Meetings 427, 511	H. S. Halcro Wardlaw 506	172, 208, 254, 286, 356, 490, 526,
Combined 427, 433, 446,	Bast, Theodore H (Life and Time	629, 666, 702, 808, 842, 876, 910, 931
458, 469, 470, 477, 478,	of Adolph Kussmaul) (rev.) 649	Booth, James 621
479, 480, 484, 485, 511, 512	Batchelor, F. S 436, 450, 521	Bostock, John 284, 441, 624, 657, 799
Medicine 481	Baxter, R. H 454, 467 Baxter, J. M. and Colin Macdonald—	Difficult Child, The 704
Naval and Military Medicine	Peanut Impacted in the Right	Mental Deficiency—
and Surgery 432, 443, 475, 489, 517		Causes and Characteristics 325
Neurology and Psychiatry 441,	Bronchus	Its Mental and Physical
466, 484	Gas Infection of the Uterus	Characteristics 255 Bower, Reginald Francis, Death of 208
Obstetrics and Gynæcology 438,	with Jaundice Following Abor-	Bower, Reginald Francis, Death of 208 Bowerbank, F. T 434, 435
451, 462, 482, 485, 513	tion	
Ophthalmology 430, 454, 475, 488	Beavis, W. R	Bradley, Burton— Notes on the Probable Life of
Orthopædics 444, 467	Begg, Campbell 461	Cercaria Catellæ, an Echino-
Otology, Rhinology and	Begg, P. Raymond 132	stome Cercaria from New
Laryngology 440, 465, 482, 514	Belisario, John 143	South Wales 673
Pædiatrics 442, 456, 488, 516	Bell, F. Gordon 449	Brady, A. J
Pathology and Bacteriology 452,	Bell, G. Gordon 512	Brain and Spinal Cord, Compen-
463, 472, 486	Bell, George 416	dium of Regional Diagnosis
Preventive Medicine and	Bell, J. R 96, 349, 659	in Affections of the. by R.
Tropical Hygiene 439, 487, 514	Berge, C. G.—	Bing (rev.) 922 Brams, W. A 653
Radiology 445, 457, 489	Bilateral Glioma Retinæ 578	Brams, W. A 653
Surgery 435, 447, 459, 472	Bergey, David D. (Bergey's	Breast, Rodman's Radical Am-
Special Meeting 517	Manual of Determinative Bac-	putations of the 285
Third Session 590, 729	teriology: A Key for the	Brett, P. G 452
Title of Congress 521 Travelling Facilities 66	Identification of Organisms of	Brisbane Hospital Clinical Society,
University of Otago, The	the Class Schizomycetes)	The 656
Visitors	(rev.) 580	British Medical Association, The 21
	Bernhard, O. (Light Treatment in Surgery) (rev.) 88	And Medical Officers, by J. S.
Australasian Medical Publishing Company, Limited, The 25	Surgery) (rev.) 88 Berkeley, Comyns and Georges M.	Purdy 171
	Dupuy (An Atlas of Mid-	Development (Leading Article) 723
Australian Medical Boards, Pro-	wifery) (rev.) 20	Federal Committee 728
ceedings of the—	Berry, R. J. A.—	Congress, Australasian Medi-
New South Wales 34, 207,	Report on the Medical Curricu-	cal (British Medical Asso-
319, 526, 702, 806, 931 Queensland 33, 526, 665, 807, 842	lum of the University of Mel-	ciation) 729
	bourne 28	Expenses of Members 728
Tasmania 207, 629, 807 Victoria 33, 319, 490, 701, 841, 931	Suggested Medical Curriculum. 64	Financial Statement 728
Antonia 50, 515, 450, 101, 641, 551	Bethea, Oscar W. (Practical	Friendly Society Lodge Prac-
Autopsies, The Pathological Le- sions Present in One Thou-	Materia Medica and Prescrip-	Goodwin, Sir Thomas, Con-
sand Consecutive to the	tion Writing) (rev.) 156	
sand Consecutive, in the Adelaide Hospital, by J. Bur-	Biggs, A. C. B 430, 513	gratulations to 729
Adelaide Hospital, by J. Bur- ton Cleland 738	Biggs, A. M 438, 449	Grants, British Medical Asso-
	Bignell, F. L 433	ciation 729
Avery, M. (Health: A Textbook	Bile Ducts, Dilatation of the 276	Hospitals, Uniform Conditions
for Schools) (rev.) 544	Bilirubin and Jaundice 724	of Medical Service in Pub-
1	Bing, R. (Compendium of Regional	Report of Subcommittee 729
В	Diagnosis in Affection of the	Lister, Centenary Celebrations
Backhouse, T. C. and R. W.	Brain and Spinal Cord) (rev.) 922	of the Birth of Lord 728
Cilento—	Biological Chemistry 195	National Health Insurance 729
Paragonimiasis: Its First Re-	"Bismol" in Syphilis, by Felton,	Office Bearers 728
corded Occurrence in New	Grimwade and Co., Pty. Ltd. 628	Pharmaceutical Council, Fed-
Guinea	Blackburn, C. B 317	eral Conference with 731

Car

Car Car

Ca Ca Ca

Page.	Page.	
British Medical Association—	British Medical Association-	Brow
Continued.	Continued. South Australian Branch—	C (
Federal Committee—Continued. Pharmacopæia, Revision of	British Medical Hall Company,	f
the British 731	Limited, The 349	C
Scholarships, British Medical	Contract Practice 63	Brum
Association 729	Council 63 Dental Board of South Aus-	Buck
Ships' Surgeons 728	tralia 349	Buck
New South Wales Branch— Annual Report of the Council 588	Fees for Commonwealth Pub-	Buck
Articles and By-laws, New 591, 870	lic Service Examination 63	Bull,
Cancer Research 591	Friendly Society Lodge Practice 63	Bull, Dea
Congress, Australasian Medi-	Meetings—	Bulln
cal (British Medical Association) 590	Medico-Political 63, 349 Scientific 131, 552, 834	Lyı
Council 588	Scientific 131, 552, 834	Bullo
Crago, W. H., Presentation of	Railway, The North-South 349 Tasmanian Branch—	Bunic
Portrait 590, 593	Annual Meeting 556	Burk
Delegates, Annual Meeting of 589 Dichotomy 590	Annual Meeting	Obs
Federal Committee 590	Health Office, Chief 556	P
Federal Model Lodge Agree-	Hospital, Public 556 Meetings, Attendance at 556	Burn
ment	Office Bearers, Election of 556	Burn
Friendly Society Lodge Con-	Post-Graduate Work 556	Butle
tract Attendance 591	President's Address, by E. Brettingham Moore 527	Byrne
Industrial Hygiene Medical	Scientific Meeting 834	Byrne
Service Contract 591 Lectures, British Medical As-	Victorian Prench	
sociation 590	Bendigo Subdivision 280	
Library 588	Annual Meeting 837 Office Bearers 837	Cabot
Library	Financial Statement 316	F
Local Associations of Mem-	List of Members 736, 842	Cæsai
bers	Meetings—	Sca
TRALIA, THE 590	Medico-Political 315 Scientific 96, 98, 280,	T
Meetings	348, 586, 620, 762, 834	I
Medico-Political 870	Papers for Meetings 593	Caller
Scientific . 164, 553, 798, 926	Sections—	Came
Scientific 164, 553, 798, 926 Membership 588	Eye and Ear 869 Office Bearers 869	
Office Bearers, Election of 592	Obstetrics and Gynæco-	Camp
Premises 590 President's Address, by R. J.	Obstetrics and Gynæco- logy	Camp
Millard 562, 592	Western Australian Branch—	Cance
Professional Confidence 590	List of Members 842	Of
Sections 589	British Medical Hall Company.	i
Neurology and Psychiatry. 553	Limited, The (South Aus-	Res
Obstetrics and Gynæco- logy 133, 248	tralia) 349	Ē
Oto-Rhino-Laryngology 312	Broben, J. A., A. H. Baldwin and G. M. Heydon—	F
Pædiatrics—	Amobic Dysentery Acquired in	I
Annual Meeting 697 Office Bearers 697	North Queensland 374	Canto
	Bronchiectasis 102, 384	Eye
Surgery 416 Workers' Compensation Act 591	Bronchoscopy 622	d
Nominations and Elections 103,	Brooks, George 147	Pel
169, 250, 317, 349, 418, 557, 593, 622, 657, 699, 732, 763, 800, 870, 927	Brown, A. E	Tre
Queensland Branch—	Hospital Practice 292	I
Division of Area of Branch 63, 315	Brown, C. J. O 452, 837	Capil
Hospital Policy 356, 556	Brown, F. V. Bevan 434, 482	S
Meetings— Joint, with Brisbane Divi-	Brown, George E. and Grace M. Roth—	10
sion of the Institution of	Biomicroscopy of the Surface	E
Engineers, Australia 284	Capillaries in Normal and	Capil
Medico-Political 556	Pathologic Subjects 499	Capra
Scientific 130, 166, 622, 656, 868 Notice 356, 876	Brown, Gilbert 252	Carbe
Post-Graduate Course in Medi-	Acute Postoperative Dilatation	Carbo
cine 735	of the Stomach	Carbo
Sections—	Introduction of Anæsthetics to	1
Ear, Eye, Nose and	Australia, The 285	Carbu
Throat 621, 868 Meetings , Arrangements	Brown, R. King 88	Carci
for 621	Browne, David D.—	Of
Officers, Election of 621	Hospital Question in Victoria, The 677 Immuno-Transfusion in Bac-	Of
Surgery 622, 837, 869	Immuno-Transfusion in Rac-	Of Of
Office Bearers 870 Scholarships and Grants 729	terial Endocarditis 578	1

Page.
Browning, Carl H., E. P. Cath- cart and Leonard Findlay
(Finiayson's Clinical Manual
for the Study of Medical
Brummitt, Robert, Death of 208
Buchanan, Sir George 349
Buckhurst, F 732
Cases) (rev.)
Bull, Richard Joseph 620, 762, 763
Bull, L. V
Lymphocythæmia 155
Lymphocythæmia 155 Bullock, Howard 416
Bunion, Operation for, by G. A. Hagenauer
Hagenauer
Pregnancy 577
Burnell, Glen H 834
Random Urological Notes 815
Burns, C. R
Butler, T 873 Byrne, Ethel 453
Byrne, J. M 660
C
C
Cabot, Richard C. (Facts on the
Heart) (rev.) 376
Cæsarean Section 204, 451 Scar in, The: With Report on
Two Cases of Rupture of the
Uterus, by Constance E.
Callen, Ivor 523
Cameron, P. D 457, 479, 485
Two Cases of Rupture of the Uterus, by Constance E. D'Arcy
Campbell, Kate 872 Cancer 197, 485 Of the Cervix Uteri, Prognosis
Of the Cervix Uteri, Prognosis
Research
By F. P. Sandes 319
Leading Article
Cantor, S. J.—
Eye Diseases of Dietetic Origin:
With Notes on a Case of Ophthalmia 822
Pellagra: A Clinical Study, with
Notes on Some Cases 713 Treatment of Hiccup Occurring
During Anæsthesia, The 858
Capillaries Biomicroscopy of the
Surface, in Normal and Pathological Subjects, by George E.
Brown and Grace M. Roth 499
Capillary Permeability 794
Capracol [see Hexyl-Resorcinol].
Carbery, A. R. D 433, 443, 444, 475, 476, 478
Carbohydrate Metabolism and In-
sulin, by John James Rickard
Macleod (rev.) 54
Carbuncle 165
Carcinoma-
Of the Breast 830
Of the Breast 835 Of the Larynx 837
Of the Breast

Page.

1y
11
11
- 613
- 208
- 349
6, 447
- 732
- 467
3, 472
2, 763
5, 838

P	age.
Carcinoma—Continued.	
of the Stomach, Gastric Ulcers	
and Duodenal Ulcers in, One Thousand Consecutive	
Autopsies at the Adelaide	
Hospital, by J. Burton Cle-	740
Prognosis in Endometrial, The	902
Cardio-Renal Disease	386
Carless, Albert (Manual of Sur-	
titioners) (rev.)	340
Hospital, by J. Burton Cleland Prognosis in Endometrial, The Cardio-Renal Disease Carless, Albert (Manual of Surgery for Students and Practitioners) (rev.) Carrington, W. L. Carswell, W. E. Jose (Illustrated Australian Encycloppedia, The: Vol. 111)	620
Carswell, W. E 475,	488
Jose (Illustrated Australian	
Encyclopædia, The: Vol. II)	
Carter P G	735
Carvosso, A. B	205
Case-Taking, Medical: A Guide for	
Clinical Clerks, by Alex. Mills	860
Cataract	165
Congenital	102
Jose (Illustrated Australian Encyclopædia, The: Vol. II) (rev.)	
conta Clinical Manual for the	
Study of Medical Cases) (rev.)	
Cato E T	613
Caven, W. R.	308
Cawadias, A. P. (Diseases of the	=00
Carcaria Catella An Echinostome	792
Cercaria from New South	
Cercaria from New South Wales, Notes on the Probable	
Life of, by Burton Bradley	673
Chambers, J. F	834
Wales, Notes on the Probable Life of, by Burton Bradley Cerebro-Spinal Fluid, The Chambers, J. F. Champion, E. Chant, E. H Chapman, Arthur Cheeseman, J. E. (Series of Drawings on Transparent Sheets for Facilitating the Reconstruction of Mental Pictures	430
Chant, E. H	758
Cheeseman, J. E. (Series of Draw-	102
ings on Transparent Sheets	
for Facilitating the Recon-	
for Facilitating the Reconstruction of Mental Pictures of the Human Body) (rev.) Cherry, P. T. S	410
Cherry, P. T. S	440
Chesney, Alan M. (Immunity in	840
Syphilis: Vol. XII of Medicine	
Monographs) (rev.)	792
Child— Difficult, The, by John Bostock	704
Difficult, The, by John Bostock Normal, The, and How to Keep	
it Normal in Mind and Morals,	CEO
it Normal in Mind and Morals, by B. Sachs (rev.)	662
Unildren—	
Abnormal Conditions in Lectures on Diseases of, by Robert Hutchison (rev.)	928
Robert Hutchison (rev.)	375
Anno MCMXXIV Editæ (rev.)	686
Chlorosis	
Cholecystitis and its Complica-	
tions, by Alan Newton 69, Cholecystography, by J. G. Ed-	
wards	78
Chorea	553
Chorioiditis, Disseminated	837
Cilento, R. W	481
And T. C. Backhouse— Paragonimiasis: Its First Re-	
corded Occurrence in New	
Guinea	79
Cinchopnen	686
Cirrhosis of the Liver, Alcoholic	164
Clark, C	698

Clauten H I	Page.
	. 317
Cleland, J. Burton 251, 252, 452, 46 463, 472, 474, 48	86.552
Blastomycosis, A Case of	
Gumma of the Interventricula	r
Sentum of the Heart Givin	2
Rise to Heart Block Healed Dissecting Aneurys	. 540
Healed Dissecting Aneurys	m
Giving Rise to the Appea	F- 538
ance of a Double Aorta And F. H. Beare— Gas Infection of the Uters	. 000
Gas Infection of the Uteru	18
with Jaundice Followin	g
Abortion	. 719
Multiple Superficial Scarrin	g
Ulcerations of the Sma	11
Intestine and Duodenal Sca	r
with Pyloric Obstruction . And J. G. Sleeman—	. 718
Pseudomyxoma Peritonei	of
Pseudomyxoma Peritonei Appendiceal Origin an	d
Mucocele of the Appendix .	. 721
Carcinoma of the Stomac Gastric Ulcers and Duodens	h,
Ulcers in One Thousand Con	n-
secutive Autopsies at th	ie
secutive Autopsies at the Adelaide Hospital Partial Rupture of the Uteru During Pregnancy with Fats	. 740
Partial Rupture of the Uteru	IS
Intraperitoneal Hæmorrhag	e 790
Pathological Lesions Present i	n
One Thousand Consecutiv	re
Autopsies in the Adelaide Ho	8-
pital Purulent Infiltration in an	. 738
Around the Thyreoid Gland.	790
Rupert Magarey and J. G. Sle	e-
man	
Gas Infections of the Uteru	IS
with Jaundice due t Bacillus Welchii Follov	.O V-
ing Abortions	. 787
Clinical Demonstrations	. 929
Clubbe, Sir Charles P. B	. 875
Bacillus Wetchi Following Abortions	3 660
Low Transverse Arrest of th	e
Fœtal Head in Occipito-Po- terior Positions	g-
terior Positions	. 52
Colitis College (see Surgeons)— Collier, F. W. D 28 Two Intussusceptions Alterna	. 616
Collier, F. W. D 28	5, 623
Two Intussusceptions Alterna	t-
ing with Two Adenomata	. 81
	317
Colon—	
Examination of the Radiological Aspect of Disease	. 457
Radiological Aspect of Disease	6 096
of the, by J. G. Edwards 91 Surgical Aspects of Diseases of	0, 940
the hy I C Storey 91	7, 926
Colauboun, K. G.—	
Urticaria Pigmentosa in Aduli	8 824
Colville, H. C	g 283
Congress [see Australasian Med	i-
cal Congress (British Medica	al
Association)]	
Congress Notes—	001
American Roentgen Ray Societ	
Conjunctivitis, Parinaud's	. 869
Coombs, Carey F. (Rheumati Heart Diseases) (rev.)	685
Coppleson, V. M. and Guy Anti	
Pockley-	
Rodent Ulcer of the Lower Eye	8-
lid Treated by Diathermy .	. 241

Corkill Basil	age. 284
Review of the Diabetes Ques-	40%
tion, A	
	514 317
On Irritable Ulcer of the Leg	011
or Malleolus, and its Cure by	782
Correspondence	
Anatomy of the Female Pelvis, The, by Frank A. Nyulasy 354,	627
Andrew Honman— By A. Correspondent By S. M. Lambert Another Matter of Greek, by	317
By S. M. Lambert	628
"Greek in Embryo"	285
H. J. WIIKINSON	525
Backfire Fracture of the Fore- arm, by "Rus in Urbe"	355
arm, by "Rus in Urbe" "Bismol" in Syphilis, by Felton,	699
Grimwade & Co., Pty., Ltd British Medical Association,	048
The, and Medical Officers, by J. S. Purdy	171
J. S. Purdy Cancer Research By I. Clunles Ross By F. P. Sandes College of Surgeons of Australasia, The, by E. S. Jack-	959
By F. P. Sandes	253 318
College of Surgeons of Australasia. The by E. S. Jack-	
son	285
James W. Barrett	628
James W. Barrett	931
Haire	319
Ethylene and Oxygen, by Gilbert Brown	806
Focal Infections, by Sydney	
Fracture of the Clavicle, by Jas. F. Merrillees Hernia, by H. C. R. Darling "Hexyl-Resorcinol," by Veader	01
Jas. F. Merrillees	33 930
"Hexyl-Resorcinol," by Veader	841
Leonard	
By Richard Arthur 253, By R. A. Parker	627 354
Introduction of Anæsthetics to Australia and Tasmania, The—	
By Gilbert Brown	285
By Gilbert Brown By Norman J. Dunlop 171, Leprosy, by E. H. Molesworth List of Members, The by R. W.	525 387
mist of Members, The, by te. W.	841
Malarial Therapy, by Eric Sus-	
Manic-Depressive Insanity, by	806
Reg. S. Ellery	207
Matter of Greek, A— By Guy Griffiths 253,	421
By Eric Jeffrey 171,	354
Medical Association of Australia, by E. S. Meyers	170
by E. S. Meyers	525
By H. B. Oxenham 170, By G. H. Taylor	354
By G. H. Taylor Milk of Australian Women, The, by H. S. Halcro Wardlaw Pernicious Anæmia or Sprue.	318
Pernicious Anæmia or Sprue, by N. Hamilton Fairley	559
Proprietary Medicines, by Phar- maceutical Society of New	333
maceutical Society of New South Wales	252
"Quackery"—	
By Guy P. U. Prior By Arthur S. Vallack	67
Quinine and Pregnancy, by L. Crivelli	

Dei

De:

Dia I

Di

Di

Di Di Di

D

D D D

D D D

D

D

I

Page.	Page.	Page.
Correspondence—Continued.	Crivelli, L.—	D
Quinine Tolerance and Preg-	Quinine and Pregnancy 354	
nancy—	Croll, D. Gifford 130, 430, 728	Dactylitis, Tuberculous 836
By K. St. V. W 253	Cross, K. Stuart 348	Daley, W. Allen and Hester Viney
By Laurence H. Hughes 421	Crowther, William L.—	(Popular Education in Public
By Philip A. Maplestone . 420	Ectopic Pregnancy in Three	Health) (rev.) 686
Quinine and Urea Hydrochloride	Sisters 610	Dalley, J. F. Halls (High Blood
Treatment of Goître, The, by	Some Medical Aspects of the	Pressure, its Variations and
H. Gerald Loughran 875 Radiation Therapy, by E. H.	Settlement at the River Der-	Control: A Manual for Prac-
Molesworth 593	went (1803-1805) 370	titioners) (rev.) 545
Radiotherapy—	Culicidæ, Notes on Malayan, by	Dansey, St. J. W 416, 448, 451
By Archie Aspinall 663, 875	A. T. Stanton (rev.) 827	D'Arcy Constance E
By H. Flecker 806	Cullen, Glenn E. and J. Harold	Chorion Epithelioma 858
By E. H. Molesworth 701	Austin (Hydrogen Ion Con-	Scar in Cæsarean Section, The:
Ramisection and Visceroptosis,	centration of the Blood in	With Report of Two Cases of Rupture of the Uterus 333
by J. Hoets 525	Health and Disease) (rev.) 545	Darling, H. C. Rutherford 926
Red Back Spider Bite-	Culpin, E 622, 868	Hernia
By Andrew Balfour 873, 910	Current Comment—	(Elementary Hygiene for
By E. S. Jackson 524	Acute Phlegmonous Gastritis 653	Nurses: A Handbook for
By H. O. Lethbridge 664	Bilirubin and Jaundice 724	Nurses and Others) (rev.) 861
By Stewart McKay 626	Capillary Permeability 794	Workers' Compensation Commis-
By E. H. Miles 353 By F. A. Rodway	"Chilling of the Liver" 759 Colitis 616	sion of New South Wales, The 524
By Arthur Watkins 873	Colitis 616	Dart. R. A
Rodent Ulcer of the Eyelid and	Diagnosis of Weil's Disease, The 583	D'Ath, E. F 473, 515
X Rays, by H. Flecker 318	Dilatation of the Bile Ducts 276	Davenport, W. K 658
Standardization of Obstetrical	Experimental Epidemiology of Tuberculosis 830	Davies, F. L 620
Treatment, The-	Tuberculosis	Davies, G. F. S 836
By J. B. Dawson 557	Harmsworth Memorial Research	Davies, Reginald 250, 317
By Mary C. de Garis 664	Fund, The 379	Wandering Endometrioma 373
By A. C. F. Halford 664	Heart Murmurs in Severe	Davis, Wolfe—
Surgeons—	Anæmía 689	Pseudo-Hermaphroditism Occur-
By "Anon" 840	Heterotopia 924	ring in Two Children in the One Family 860
By "G.P." 874	Immunization against Diph-	One Family 860 Davison, Wilburt C. and Selman
By "Kept in the Dark" 874	theria 244	
Surgical Conscience, by "General	Industrial Hygiene in Japan 309	A. Waksman (Enzymes: Properties, Distribution,
Practitioner" 930 -Sympathetic Ramisection—	Islands of Langerhans in the	Methods and Applications)
By N. D. Royle 841	Human Pancreas, The 617	(rev.)
By A. R. Southwood 318	Journal of the Medical Associa-	Dawson, J. B.—
Treatment of Snake Bite-	tion of South Africa (British Medical Association), The 277	Standardization of Obstetrical
By Keith G. Kerr 873	Leptomeningioma of the Spinal	Treatment, The 557
By A. MacInnes 771	Cord 652	Dawson, W. S 798
By D. P. O'Brien 909	Cord	Day, A. J 763
By Arthur Palmer 873	Medical Advice to Ships at Sea 413	Death—
By R. A. Parker 930	Melanosis and Cancer of the	Sudden, The Pathology of Two
By Sydney Pern 871	Bowel 197	Cases of, by Oliver Latham 121
By Arthur Watkins 665	Paget's Disease of the Nipple 864	Defectives, The Education and
Wanted: Ticks, by Stewart	Pancreatitis 412	After Care of Mental 466
McKay 32 Workers' Compensation Com-	Pneumonic Plague 378	De Garis, Mary C. 430, 447, 463, 486, 513
mission of New South Wales,	Prognosis in Cancer of the	Standardization of Obstetrical
The, by H. C. Rutherford	Cervix Uteri 690	de Lamar Lectures, 1925-1926, The,
Darling 524	Prognosis in Endometrial Car-	
Correspondence, Special-	Relation of Pulse Rate to Tem-	of the School of Hygiene and Public Health, Johns Hopkins
London Letter 420, 662, 908	perature, The 582	University (rev.) 722
Correspondent, A-	Significance of Gastric Anacidity,	Delinquency 478
Andrew Honman 317	The 196	100
Correspondents, Replies to 841	Streptococcus in Poliomyelitis,	
Corrigenda 103, 665, 807, 910	The 549	Denehy, W. J 466
Corscaden, James A. (History	Syphilis of the Liver 308	Dengue as a Cause of Death, by
Taking and Recording) (rev.) 792	Syphilitic Arthritis 344 Tick Paralysis 548	F. McCallum and J. P. Dwyer 10
Counseller, V. S 276	Tick Paralysis 548	Dennis, C. E 417
Cowell, Ernest M. (Hernia and	Toxicity of Human Serum, The 758	Dental Board of South Australia.
Hernioplasty) (rev.) 861	Treatment of Myelomata 345	The 349
Cowen, S. O 280, 625, 626	Ventral Hernia 245 Visit of Dr. Kanavel and Pro-	Dental Extraction in its Relation
Cox, H. D. B 732	fessor Elliot 903	to Surgery, by Leonard C. E.
Crago, W. H		Lindon 111, 131
Presentation of Portrait . 590, 593	Curriculum, Medical (University	Dental Society of South Australia 131
	of Melbourne), Report on	
Craig, F. Brown 592, 593, 870, 926	and Suggested, by R. J. A.	Derham, A. P 62, 63, 101,
Craig, Gordon 437,	Berry 28, 64	382, 762, 870, 871
450, 459, 460, 461, 472, 480	Cuscaden, W 418	Dermatological Practice, Observa-
Cretinism 102, 103	Cyanosis, Periodical, Followed by	tions on Certain Therapeutic
Criminality and Mental Deficiency	Melæna 280	Measures in, by W. Upton 715
(Leading Article) 581	Cyst, Mesenteric, Simulating Acute	Dermatology 158
Cripple from War and from In-	Post Partum Dilatation of the	Fundamentals of by Alfred
dustry, The 477	Stomach, by Alan E. Lee 83	Schalek (rev.) 242

Page.

5 8 2

Page.	Page.	Page.
Derwent River, Some Medical	Duodenal—	Endocarditis-
Aspects of the Settlement at	Lesions, X Ray Diagnosis of 457	Immuno-Transfusion in Bac-
(1803-1805), by William L.	Surgery 447 Tube, The, and its Possibilities,	terial, by D. D. Browne 578
Crowther	by Max Einhorn (rev.) 306	Rheumatic, and Pericarditis 282 Subacute Bacterial, by G. A.
Development (Leading Article) 723	Ulcers 458	Kaye and N. B. White 859
Devine, H. B 348, 437, 447, 450, 462	Duodenum, Cyst of the, by K.	Endometrioma 250
Clinical and Radiological Diffi-	Maddox 900 Dupuy, Georges M. and Comyns	Wandering, by Reginald Davies 373
culties in the Diagnosis of Lesions of the Prepylorus and	Berkeley (An Atlas of Mid-	Endo-Pericarditis, Rheumatic 282 Enteric Fever 660, 662
Posterior Gastric Wall 330	wifery) (rev.) 20	Enzymes: Properties, Distribu-
Dew, H. R 470, 625	Durie, Ethel B 464	tion, Methods and Applica
Dextrocardia, Complicated, by	Dwyer, J. P. and F. McCallum— Dengue as a Cause of Death 10	tions, by Selman A. Waksman and Wilburt C. Davison
James E. Sherwood720 Diabetes—	Dysentery, Amebic, Acquired in	(rev.) 792
Insipidus 445	North Queensland, by A. H.	Epidermolysis Bullosa 102
Mellitus 165	Baldwin, G. M. Heydon and J. A. Broben 374	Epilepsies of Childhood, The, by
Simplification of the Dietetic	Dyspepsias, Reflex 457	A. W. Campbell
Treatment of, by R. Coupland Winn 321	Dystrophy, Muscular 103, 872	P. U. Prior 775, 798, 841
Question, A Review of the, by	E	Epiphysitis
Basil Corkill 46	i.	stance E. D'Arcy 858
Diagnosis, Cases for 284, 624, 928 Diarrhea, Infantile, by R. L.	Eadie, Clive M.—	Erythema Nodosum 251
Forsyth 407	Tonsillectomy with the Guillo- tine 676	Erythrædema 516
Diary for the Month 34,	Eagleton, Wells P. (Cavernous	Ether (Anæsthesia and the Newer Anæsthetics)—
68, 104, 136, 172, 208, 254,	Sinus Thrombophlebitis and	by Reginald Howden 596, 620
286, 320, 356, 390, 422, 490, 526, 560, 594, 630, 666, 702,	Allied Septic and Traumatic Lesions of the Basal Verous	Intratracheal Administration of,
736, 772, 808, 842, 876, 910, 931	Sinuses) (rev.) 54	by F. W. Green 598, 629 Ethylene and Oxygen (Anæsthesia
Diathermy—	Ear Disease, Middle 483	and the Newer Anæsthetics)—
Rodent Ulcer of the Lower Eyelid Treated by, by Guy	Earlam, M. S	By G. Leonard Lillies 601, 629
Antill Pockley and V. M.	(rev.) 922	By Gilbert Brown 806 Evans, Frank A. (Pernicious
Coppleson 241	Eclampsia 201	Anemia) (rev.) 305
Dichotomy 590	Eczema, Ætiology and Treatment	Ewart, E. D. (Guide to Anatomy
Dick, J. Adam 728, 870 Diet	of Infantile, by Frank Trinca 152 Edgar, J. Clifton (Edgar's Prac-	for Students of Medical Gym- nastics, Massage and Medical
Dietetics, A Manual in Pre-	tice of Obstetrics) (rev.) 340	Electricity) (rev.) 156
liminary, by Maude A. Perry	Editorial Notices 34, 68, 104, 136, 172, 208, 254, 286, 320, 356, 390,	Expedition to the Great Barrier
(rev.)	422, 490, 526, 560, 594, 630, 666,	Reef, An
Exophthalmic Goître 123	702, 736, 772, 808, 842, 876, 910, 932	With Notes on a Case of
Digestive System, Diseases of the (Vol. III of Osler's Medicine)	Edwards, J. G	Ophthalmia, by S. J. Cantor. 822
(rev.) 409	Radiological Aspect of the Dis-	F
Diggle, J. L 97, 659	eases of the Colon 916	.1: 0.1
Digitalis Compounds 552	Ehrenfest, Hugh 242 Einhorn, Max (Duodenal Tube	Fairley, K. D 386, 626
Diphtheria 660, 662 Forecasting Outbreaks of 487	and its Possibilities, The)	Fairley, N. Hamilton—
Immunization against 244	(rev.) 306	Pernicious Anæmia or Sprue 559 Fatigue, Industrial 514
Disclaimer, A, by Norman Haire 319	Elder, A. Vavasour (Ship-Surgeon's Handbook, The) (rev.) 649	Falconer, A. R 467, 476
Disher, H. C 762	Electro-Cardiograms, The Inter-	Fallopian Tubes, Insufflation of
Dislocation of the Head of the	pretation and Clinical Signi-	the 438
Radius 927 Dixon, Cyril 488	ficance of Certain, by Eric F. Gartrell 528, 552	Feeding in Infancy and Childhood, Modern Methods of, by Donald
Dixon, Cyril	Electrothermic Methods in the	Paterson and J. Forest Smith
Douglas, J. C.—	Treatment of Neoplastic Dis-	(rev.) 340
Some Ophthalmic Cases 609	eases, by J. Douglas Morgan (rev.)	Fellowship of Medicine, The 420, 908 Felton, Grimwade & Co., Pty.,
Downes, Rupert 872	Ellery, Reg. S 625	Ltd.—
Downing, J. Horace—	Malarial Therapy in General	"Bismol" in Syphilis 628
Ulcero-Membranous Stomatitis 273	Paralysis 647 Manic-Depressive Insanity 207	Fenton, C. C.— Rheumatoid Arthritis Treated
Drennan, A. M 428, 434, 474, 513, 521	Psychoses of the Puerperium 287	at Paralana Hot Springs,
Dressing Station, Work at an	Elliott, Charles 172, 805, 903, 929	South Australia 681
Advanced 489	Ellis, Constance	Fenwick, D. E 481 Fenwick, George E. O 431, 432, 475
Drolet, Godias J. (Tuberculosis	Empyema in Adults: The Results	Fenwick, P. Clennell 489
Hospitalization) (rev.) 650	of an Analysis of the Records	Ferguson, E. W 548
Dudgeon, L. S 617	of Empyemata Treated at Mel- bourne Hospital, 1919-1924, by	Ferguson, J. Bell (Quartz Mercury Vapour Lamp, The: Its Possi-
Dudley, S. F	J. R. Williams 710	bilities and Uses in Public
Dunley Norman I	Encephalitis Lethargica, The	Health and General Practice)
Dunlop, Norman J.— Essay Relating Chiefly to Anæs-	Sequelæ of 511 Encyclopædia, The Illustrated Aus-	(rev.)
thetics and Their Introduc-	tralian, edited by Arthur Wil-	Fetherston, R. H 728
tion to Australia and Tasmania, An 141, 171, 525	berforce Jose and Herbert	Ffrost, A. E 280
поша, Ан 141, 1/1, 525	James Carter: Vol. II (rev.) 52	Fiaschi, P 416, 926

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Ha: Ha:

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Ha I

Ha Ha Ha

Ha He He He

H

H

HHH

Page.	Page.	Page.
Fiaschi, Thomas Henry, Death	G	Gordon, C. H 470
of 665, 732		Gordon, Doris C 513
01	"G.P."—	Gordon, Kenneth F 433, 489
Fibroma of the Vocal Cord 315		Gordon, Kenneth F 100, 105
Fifield, Lionel R. (Infections of	Surgeons 874	Gout 164
the Hand) (rev.) 544	Gaffney Burke 283	Gowland, W. P 520, 521
	Galbraith, Douglas 102, 382, 586, 872	Graham H Royd 99 382 587 879
Findlay, Leonard, Carl H. Brown-	Calbraith, Douglas 102, 002, 000, 012	Count D. I. Mhoneld
ing and E. P. Cathcart (Fin-	Galvanism, The Effect of, on the	Gowland, W. P 520, 521 Graham, H. Boyd 99, 382, 587, 872 Grant, R. L. Thorold—
layson's Clinical Manual for	Treatment of Denervated	Herpes Zoster and Varicella
the Study of Medical Cases)	Muscle, by Norman D. Royle 409	Occurring Simultaneously in
	Garde, M. L 523	the Same Person 192
(rev.) 613	Garde, M. 1	
Finlay, Sinclair, Death of 254, 352	Gardiner, Mark 837 Gardiner, S. S 284, 622	Graves's Disease [see Goître, Ex-
Fisher Wilhy 450	Gardiner, S. S 284, 622	ophthalmic].
Fisher, Wilby	Gartrell, Eric F 552	Gray, H. J 466, 483, 484
Fitchett, F		Great Britain and Decadence 342
Fitzgerald, A. J. and Leslie Utz-	Blood Pressure in the Leg in	
Autogenous Vaccines in Infec-	Aortic Regurgitation 642	Greek—
tions of the Respiratory Tract 15	Interpretation and Clinical Sig-	A Matter of—
	nificance of Cortain Electro-	By Guy Griffiths 253,421
Flecker, H. 280, 281, 417, 835, 871, 872		Dr. Whie Toffner 171 954
Radiotherapy 806 Radiotherapy: Why is this	Cardiograms, The 528	By Eric Jeffrey 171, 354 Another Matter of, by "Greek in
Radiotherapy: Why is this	Gas Attacks, Protection of the	Another Matter of, by "Greek in
Form of Treatment Not More	Civil Population Against 517	Embryo" 285 "Greek in Embryo"—
Consender Complement 2100 More	Gastrie-	"Greek in Embryo"-
Generally Employed? 302		Another Metter of Cheek
Rodent Ulcer of the Eyelid and	Anacidity, The Significance of 196	Another Matter of Greek 285
X Rays 318	And Duodenal Condition, X Ray	Green, F. W 620, 621
Fluke Infestation, Liver 658	Examination in the Diagnosis	Intratracheal Administration of
	of 348	Ether, The (Anæsthesia and
Flynn, James—	And Duodonal Comment	
Retrobulbar Neuritis Associated	And Duodenal Surgery 447 Ulcers	the Newer Anæsthetics) 598
with Sphenoidal and Ethmoidal	Ulcers 458	Green, John S 200
	Wall, Clinical and Radiological	Green T E 281 282
Sinusitis 543	Difficulties in the Diagnosis	Greenslade, C. M 450 Gregory, Hazel H. Chodak (In-
Flynn, M. R 556, 660		Greensiage, C. M
	of Lesions of the Prepylorus	Gregory, Hazel H. Chodak (In-
Food—	and Posterior, by H. B. Devine 330	fant Welfare for the Student
And the Principles of Dietetics,	Gastritis, Acute Phlegmonous 653	and Practitioner) (rev.) 510
by Robert Hutchison (rev.) 579		
	Gauvain, Sir Henry J 510	Gribben, St. L. H 442, 467, 479, 484
Factors, Accessory 901 Inspection 661	Gay, L. N 758	Grieve, J. W 103, 870
inspection bbl	General Paralysis—	Griffiths, Guy-
Supply for Natives in the	Juvenile 556	Matter of Greek, A 253, 421
Territory of Papua, by W. M.		
	Malarial Therapy in, by Reg. S.	Groves, W. R 283, 284
Strong 607, 665	Ellery 647	Recollections and Impressions
Foods and Drugs Act (Tas-	"General Practitioner,"—	After Twenty-Four Years of
mania) 662		Country Practice 265
Foreign Bodies in the Stomach 656	Surgical Conscience 930	
	Gibson, J. Lockhart 135, 621,	Treatment of Peritonitis, The 260
Foreign Body in the Bladder 656	622, 868, 869	Gulley, F. P 732
Foreign Body in the Lung 625	Lister Centenary Oration 844	Gumma of the Interventricular
Forsyth, R. L 382, 871		
Infantile Diarrhœa 407	Gifford Edmonds Prize in Oph-	Septum of the Head Giving
Treater D Charles	thalmology, The 285	Rise to Heart Block, by J.
Foster, P. Stanley 448		Burton Cleland 540, 552
Foulerton Research Studentship,	Gilmour, W 472, 473, 474	Gunn, Elizabeth 447
The 207	Cincipitia Channia 900	Contheir T
Fowler, R 417	Gingivitis, Chronic 386	Guthrie, J
Powier, It.	Glandular Enlargement, General-	Guthrie, R. Neil 445, 457, 470, 471
Foxton, H. V 556, 622, 656, 868, 869, 870		Gutteridge, E 482, 514
622, 656, 868, 869, 870	ized 280, 625	
Fracture-	Glioma—	Guy, C 653 Gynæcological Operations, Some
	Of the Optic Nerve 622	Gynæcological Operations, Some
Of the Clavicle, by Jas. F. Mer-		Bad Results of, by R. I. Fur-
rillees 33	Retinæ, Bilateral, by C. G. Berge 578	ber 115, 133
Of the Elbow, Sequel to, by S.	Glissan, D. J 416	Gynæcology 58
Goldberg		Gynacology 33
	Goddard, C. E.—	
Of the Femur, Intertrochanteric 165	Address on Lord Lister 850	H
Of the Forearm, Backfire, by	Godsall, R. S 314	
"Rus in Urbe" 355	the state of the s	Hæmorrhage
Of the Humerus 99	Goître 427	
		Accidental 203
Fractures, The Treatment of,	Exophthalmic 102, 836	Case of Concealed Accidental, by
with Notes upon a Few Com-	By J. Eason (rev.) 922	H. A. Ridler 273
mon Dislocations, by Charles	By O. A. A. Diethelm 123, 665	Intraocular 868
	Metamorphosis from Simple to	Intraocular
Locke Scudder (rev.) 791	Toxic 433	Hagenauer, G. A.—
Frambæsia 481	10210 100	Operation for Bunion 787
Frecker, E. W	Ocular Signs of, The 431	
	Quinine and Urea Hydro-	Haire, Norman-
Case of Scurvy, A 274	chloride Treatment of, The,	A Disclaimer 319
French, Herbert and Tallent	by H. Gerald Loughran 875	Hajek, M. (Pathology and Treat-
Nuthall (Medical Laboratory		
Methods and Tests) (rev.) 580	Surgery of, The 435	ment of the Inflammatory Dis-
	Treatment of, by Injection of	eases of the Nasal Accessory
Friedreich's Ataxia 282	Quinine and Urea Hydro-	Sinuses) (rev.) 192
Friendly Society Lodge Practice-		Halford, A. C. F
Australia 730	chloride into the Thyreoid	Charles de Charles Constitution de Charles d
	Gland, by H. G. Lough-	Standardization of Obstetrical
South Australia 63, 591	ran 263, 283	Treatment, The 664
Fugue, Hysterical 555		Hall, A. J 431, 432, 456,
	Goldberg, S.—	466, 475, 488
By S. Evan Jones 541	Sequel to Fracture of the Elbow 611	
Funk, Elmer H 409	Goldstein, B 689	Hall, R. D. McKellar—
		Unusual Type of Intussuscep-
Furber, R. I	Good, Norman 62 Goodwin, Sir Thomas, H. J. C. 656,	tion, An 304
Some Bad Results of Gynæco-	Goodwin, Sir Thomas, H. J. C. 656,	
logical Operations 115	729, 876	Halley, G 440

Page. . 470 . 513 3, 489 . 164 0, 521 7, 872

, 484 342

484 870

284

260 732

58

P	Dome	
Halloran, Garnet 314	Page.	Hospital—Continued.
Hallows, B. R 659	And Hernioplasty, by Ernest M.	Housekeeping and Sanitation,
Hamilton, Thomas 285	Cowell (rev.) 861	by Nora P. Hurst (rev.) 756
Hospital Questions in New South Wales, The 856	By H. C. R. Darling 930 Ventral 245	Melbourne 384, 624
Hance, J. B 345	Herpes Zoster and Varicella Oc-	Launceston, Public 928 Newcastle 284, 622, 657
Hand, Infections of the, by Lionel	curring Simultaneously in the	Policy, The
R. Fifield (rev.) 544	Same Person, by R. L. Thorold	(Leading Article) 793
Hansel, French K	Grant 192 Herpes Ophthalmicus, by J. B.	Practice, by A. E. Brown 292 Question in New South Wales,
Hanzlik, P. J. (Actions and Uses	Lewis	The, by Thomas Hamilton 856
of the Salicylates and Cincho-	Hewlett, H. M 348	Question in Victoria, The, by
phen in Medicine) (rev.) 686	X Ray Examination of the Stomach	David D. Browne 677
Harcourt, Clive	"Hexyl-Resorcinol," by Veader	Royal Alexandra, for Children (Sydney) 697
Hardwick-Smith, H 436	Leonard 841	Staffs (Leading Article) 757
Harmsworth Memorial Research	Heydon, G. M 454	Victorian Eye and Ear 869
Fund, The	And A. H. Baldwin and J. A. Broben—	Hospitals 757
Harris, R. Hamlyn 130, 131 Biological Side of Mosquito	Amœbic Dysentery Acquired	Hospitals Act, The (Tasmania) 662
Control, The 108	in North Queensland 374	Hospitals, Public, Uniform Condi- tions of Medical Service in 729
Harris, S. Harry 460, 462 Harty, G. W 431, 432, 455	Differences Between the Infec- tive Larvæ of the Hookworms	Hospitals, State, and Practitioners,
Hassard, E. M. and A. R. (Prac-	of Man, The 531	The Relationship Between 517
tical Nursing for Male Nurses	Hibbs, Russell A. and Alan De F.	Hour Glass Contraction of the Stomach 659
in the R.A.M.C. and Other	Smith—	Houston, Thomas 104
Forces) (rev.)	Joint Tuberculosis 810 Hiccup Occurring During Anæs-	Howard, Harvey J. (Ten Weeks
Hays, H 483	thesia, The Treatment of, by	with Chinese Bandits) (rev.) 686
Head, Henry	S. J. Cantor 858	Howden, Reginald 620, 621 Ether (Anæsthesia and the
	Hicks, C. S	Newer Anæsthetics) 596
Health— Public—	Hiller, Konrad 384, 386	Howell, W. H. (de Lamar Lectures,
Allen Daley and Hester	Hip, Conditions of the 929	1925-1926) (rev.) 722 Hughes, Laurence H.—
Viney (rev.) 686	Hipsley, P. L 452	Quinine Tolerance and Preg-
Health Organization of the League of Nations 906	Hirschsprung's Disease 456, 554, 872 Operative Treatment of, The:	nancy 421
In Greater Brisbane, by H.	A New Method, by R. B. Wade	Hughes, T. Dixon— Arsenical Neuritis Treated by .
W. Tilling 105, 130	and Norman D. Royle 137	the Intravenous Injection of
Industrial Hygiene 699	History Taking and Recording, by James A. Corscaden (rev.) 792	Sodium Thiosulphate 542
(Leading Article) 687 National Health Insurance,	Hoare, W. W 868	Hughes, W. Kent 281
Report of the Royal Com-	Hodgkin's Disease 658	Hunter, Richard H. (Short History of Anatomy, A) (rev.) 826
mission 763, 800	Hoets, J.— Ramisection and Visceroptosis 525	Hurley, Leslie 385, 386, 626
Popular Education in, by W. Report of the Commissioner	Hogarth, T. W 872	Hurley, Victor 281, 282, 283
of (Queensland) 660	Hogg, C. A 467, 581, 799	Hurst, A. F 616 Hurst, Nora P. (Hospital House-
Report of the Department of	Hogg, G. H 556, 834 Optic Neuritis as a Complication	keeping and Sanitation) (rev.) 756
(Tasmania) 661	of Whooping Cough 825	Hutchinson, Robert-
Textbook for Schools, A, by M. Avery (rev.) 544	Holman, W. P. and Alan Pryde-	(Lectures on Diseases of
Heart—	Perthes's Disease 753	Children) (rev.) 375 (Elements of Medical Treat-
And Lungs, Diseases of the: A	Hone, R	ment. The) (rev.) 375
Handbook for Nurses, by A. I. G. McLaughlin (rev.) 826	By a Correspondent 317	(Food and the Principles of
Disease-	By S. M. Lambert 628	Dietetics) (rev.) 579
And Life Assurance 552	New Year 103	Hydatid Disease— Diagnosis and Surgical Aspects
Congenital 872 Modern Methods in the Diag-	Birthday 875	of, The 479
nosis and Treatment of, by	Hood, Lionel 103, 870, 872	Medical Aspects of 470
Francis Heatherley (rev.) 20	Hookworm—	Hydatid of the Lung 835
Facts on the, by Richard C. Cabot (rev.) 376	Disease	Hydrogen Ion Concentration of
Pathological Lesions of the 552	Hookworms of Man, The Differ-	the Blood in Health and Dis-
Heatherley, Francis (Modern	ences Between the Infective	ease, by J. Harold Austin and Glenn E. Cullen (rev.) 545
Methods in the Diagnosis and	Larvæ of the, by G. M. Heydon 531	
Treatment of Heart Disease) (rev.)	Hooper, J. W. Dunbar 438, 463, 486	Hygiene 194, 722, 861 Industrial, in Japan 309
Hector, C. M	Hopkirk, C. S. M 472	Teaching of, in Schools, The,
Heitger, Joseph D 192	Hornabrook, R. W	by Harvey Sutton 668
Hemanopia, Postoperative 623 Hemigiantism, Congenital 280	List of Members, The 841	Hylton, Rex 383, 872
Hemiplegia, Progressive 385	Hosking, H. C 872	Hyperemesis gravidarum 202
Hépatites Dysentériques, Les, et	Hospital— Alfred 658, 927	Hyperpyrexia, A Case of, by C.
leur Traitement, par A. Valas-	Alfred 658, 927 Austin (Heidelberg) 834	Humphrey Lloyd 684
sopoule et Pavlos Pétridis	Bendigo 837	Hypertelorism 871
(rev.)	Brisbane General 656	Hypnotic Suggestion— By Idris Morgan 85
Hercus, C. E 427, 430, 459,	Children's (Melbourne) 62, 382, 870 Hobart 556	By R. A. Parker 354
479, 485, 487, 514	Coast (Sydney) 164	By R. A. Parker 354 By Richard Arthur 253, 627

Lei Lei Lei Lei Lei Lei

> Li Li

	·	
Page.	Page.	Page
Hysteria 657	Jackson, E. Sandford 130,	Kinsella, V. J 62
Conversion 555	131, 166, 556, 622, 838, 869	Knaggs, R. Lawford (Inflamma-
Hysterical Fugue 555	College of Surgeons of Austral-	tory and Toxic Diseases of
By S. Evan Jones 541	asia, The 285	Bone, The: A Textbook for
	Red-Backed Spider Bite, The 524	Senior Students) (rev.) 54
I	Jacobs, H 200	Knee Joint, Tuberculous Disease
	Jacobs, M 280	of the 16
Illingworth, H. T.—	Jamieson, J. P. S 452	Koehler, Robert (Therapy of Puer-
Carcinoma of the Right Lung. 611	Jay, H. M	peral Fever, The) (rev.) 24
Immunology 159	Proptosis: Some Interesting	Kose, Yasutoshi 30
Industrial Hygiene	Cases	Kuatsu
Infancy and Childhood, Preven-	Matter of Greek, A 171, 354	Kussmaul, Adolf, The Life and
tion of Diseases in, The 469	Jellett, H 438, 439, 451, 452, 463	Time of, by Theodore H. Bast
Infant Feeding 442	Jenkins, J. A 450, 461	(rev.) 64
Infant Welfare—	Jerman, E 522	(2011) 11 11 11 11 11 11
Experiences Abroad with	Johnson, T. W. J 482	L
Special Reference to, by Vera	Johnston, H. Huff 315	
Scantlebury 35, 62	Johnstone, R. W. (Text-book of	Laboratory Methods and Tests.
For the Student and Practi-	Midwifery for Students and	Medical, by Herbert French
tioner, by Hazel H. Chodak	Practitioners, A) (rev.) 649	and Tallent Nuthall (rev.) 58
Gregory (rev.) 510 Infantile Dietetics 103	Jones, D. W. Carmalt 467, 481,	Labour—
Infantile Dietetics 103	521, 547, 582	Normal, The Management of 20
Infection, Gas, of the Uterus with	Relations of Temperature and	The Trial 46
Jaundice Following Abortion,	Pulse Rate in Disease, The:	Labours, Abnormal 20
by F. H. Beare and J. Burton	A Clinical Study 491	Lachrymal Obstruction, Operative
Cleland 719	Jones, Isaac 441	Treatment of 43
Infections— Focal, by Sydney Pern 67	Jones, S. Evan	Laidley, J. W. S 31
Gas, of the Uterus with	Hysterical Fugue 541	Lambert, S. M
Jaundice due to Bacillus	Jones, W. Ernest 484 Jose, Arthur Wilberforce and H.	Andrew Honman 62
Welchii Following Abortions,	J. Carter (Illustrated Austra-	Lambert, T. E.—
by Rupert Magarey, J. Burton	lian Encyclopædia, The: Vol.	Head Injuries 67
Cleland and J. C. Sleeman 787	II.) (rev.) 52	Lamson, O. F
Non-Suppurative Intraocular 454	Journal of the Medical Associa-	Lancet, The, Extra Numbers, No. 2
Inflammation and Tumours of	tion of South Africa (British	(Early Mental Disease) (rev.) 41
Bone 512	Medical Association) 277	Lash, A. F 79
Influenza-	Joyce, A 869	Latham, Oliver 441, 442, 466, 472, 485, 55
By J. P. Major 744, 762		Pathology of Two Cases of
Its Epidemiology and Preven-	K	Sudden Death, The 12
tion, by Frank R. Kerr. 747, 762	IZ C4 IZ IV	Laurie, H
Pathology and Clinical Features	K. St. V. W.— Quinine Tolerance in Pregnancy 253	Laurie, W. Spaulding 62, 870.
of, by R. P. McMeekin 750, 762	Kahn, R. L. (Serum Diagnosis of	871, 927, 92
Ingamells, L 252	Syphilis by Precipitation:	Lawrence, A. P 51
Inge, Dean 342 Inglis, W. Keith 512	Governing Principles, Pro-	Lawson, A. Anstruther 65
Injury—	cedure and Clinical Applica-	Lawton, F. B 384, 62
To Eye by Explosion 868	tion of the Kahn Precipitation	Lead Poisoning 69
To the Cauda Equina 164	Test) (rev.) 650	Lead Treatment of Malignant
Insanity, Manic-Depressive, by	Kahn Reaction, The 473	Disease 812, 83
Reg. S. Ellery 207	Kahn Reaction, The 473 Kanavel; Allen 172, 805, 903, 929	
Insects of Australia and New	Kaufmann, Mark 412	Leading Articles—
Zealand, The, by R. J. Till-	Kaye, G. A. and N. B. White-	Accessory Food Factors 90
yard (rev.) 826	Subacute Bacterial Endocarditis 859	Cancer Research 27
Insulin and Carbohydrate Metabol-	Keefer, C. S 196	College of Surgeons of Aus-
ism, by John James Rickard	Keith, Sir Arthur 861	tralasia, The 24
Macleod (rev.) 54	Kellaway, C. H 452, 465, 479 Kellogg's "Corn Flakes" 827 Kelly, John H 102	Criminality and Mental Deficiency
Insurance, National Health 729	Kelly John H	Development 72
Report of the Royal Commis-	Kennedy, Alex. Mills (Medical	Dunedin Congress and After.
sion 763, 800	Case Taking: A Guide for	The 54
Leading Article 829 Recommendations 804	Clinical Clerks) (rev.) 860	Exordium, The 37
	Kennedy, John 659	Hospital Policy, The 79
Intestines, Diseases of the, by A.	Kenny, A. L 134, 350	Lister's Greatness 86
P. Cawadias (rev.) 792	Kenny, A. L 134, 350 "Kept in the Dark"—	Mental Deficiency 34
Intussusception—	Surgeons 874	National Insurance 82
Ileal, in an Adult, by Alan	Keratitis, Interstitial 868	Noblesse Oblige 75
Pryde 648	Kerr, Frank R 762, 763	Prevention of Venereal Disease,
Unusual Type of, by R. D.	Influenza: Its Epidemiology and	The 30
McKellar.Hall , 304	Prevention 747	Public Health, The 68
Intussusceptions, Two, Alternat-	Kerr, Keith G.—	Resolutions of Congress 61
ing with Two Adenomata of	Snake Bite 873	Surgeons 65
the Small Bowel, by F. W. D.	Kerwin, P. J	Ultra-Violet Rays 92
Collier 81		Unqualified Nurses 41
w) 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Kilduffe, Robert A. (Clinical In- terpretation of the Wasser-	League of Nations 37
J	mann Reaction, The) (rev.) 579	Health Organization 90
Jack, William R. (Wheeler's	Kilvington, Basil 348,	Leahy, M. P. (Mind in Disease,
Handbook of Medicine) (rev.) 861	384, 385, 386, 435, 438, 461, 839	The: Some Conditions Cured
Jackson, Edward (Contributions	King, Sir F. Truby 443	by Suggestion) (rev.) 15
to Onbtholmic Colones) (now) 974	Kinna Alwyn I. 441	Learmonth, J. R

P	age.
Leary, T. Garnet— Stammering as a Psychoneurosis: A Plea for Cor-	
neurosis: A Plea for Cor-	
rective Measures	299
Lectures, The de Lamar, 1925- 1926, of the School of Hygiene and Public Health, Johns Hopkins University (rev.)	
and Public Health. Johns	
Hopkins University (rev.)	722
Lee, Alan E 656, Mesenteric Cyst Simulating	657
Mesenteric Cyst Simulating	
Acute Post Partum Dilatation	83
Lee Brown, R. K	459
Le Messurier, F. N	349
Legg's Disease	928
Lendon, Guy	131
Acute Post Partum Dilatation of the Stomach Lee Brown, R. K. Le Messurier, F. N. Legg's Disease Lendon, A. A. 251, Lendon, Guy Leonard Veader— "Havyl Resercinol"	
"Hexyl-Resorcinol"	841
Leprosy, by E. H. Molesworth	387
Cord.	652
Lethbridge, H. O	487
Red Backed Spider, The	664
Leuchæmia, Myelold	688
Lewis, J. Brook	431
Herpes Ophthalmicus	124
Lewis, J. Monahan	386
Light Treatment in Surgery, by	010
O. Bernhard, Translated by	
R. King Brown (rev.)	88
Ethylone and Oxygen (Anges-	021
Lendon, Guy Leonard Veader— "Hexyl-Resorcinol" Leprosy, by E. H. Molesworth Leptomeningioma of the Spinal Cord. Lethbridge, H. O. Red Backed Spider, The Leuchæmia, Myeloid Leucocytic Tide, The Lewis, J. Brook Herpes Ophthalmicus Lein-Teh, Wu Light Treatment in Surgery, by O. Bernhard, Translated by R. King Brown (rev.) Lillies, G. Leonard Ethylene and Oxygen (Anæsthesia and the Newer Anæsthesia and the Newer Anæsthetics) Lind, Frank Lind, W. A. T.— Suicide	
thetics)	601
Lind, Frank	586
Suicide	679
Suicide	131
Dental Extraction in its Rela-	111
Lindsay H Bonar 462.	463
Lindsay, W. S	902
Lines, D. H. E 135,	834
"Lipiodol Ascendens"	485
List of Members. The, by R. W.	100
Hornabrook	841
Lister, Address on Lord, by C. E.	850
Dental Extraction in its Relation to Surgery Lindsay, H. Bonar	908
Oration—	
By J. Lockhart Gibson 844,	868
By R. Marshall Allan Lister's Greatness (Leading	
Article)	863
Article)	770
Little's Disease	281
"Liver, Chilling of the"	759
Lloyd, C. Humphrey—	100
Case of Hyperpyrexia, A	684
Lodge Practice [see Friendly	
Society].	
Lodge, Sir Oliver	722
London Letter— By Our Special Correspon-	
By Our Special Correspondent 420, 662,	908
Lorand, Arnold (Defective Memory,	
Absentmindedness and their	
Treatment) (rev.)	756
Lord, J. R. (Clinical Study of Mental Disorders, The) (rev.)	375
Loughnane, F. McG. (Handbook of	3.0
Renal Surgery, A) (rev.)	545
- collect contract contract	

June 25, 1927.

THE MEDICAL COUNTY
Page.
Loughran, H. G 283, 284 Quinine and Urea Hydrochloride
Quinine and Ures Hydrochloride
Treatment of Goître. The 875
Treatment of Goître, The 875 Treatment of Thyreoid Enlarge-
ment Including Exophthalmic
Goître by Injections of
Goître by Injections of Quinine and Urea Hydro-
Gland 263
Gland
Lovell P Coulburn (Why Tuber-
culoric eviete How it May he
and has been Cured and
Prevented) (rev.) 613
Lunus of the Pharvny 315
Lymphangitic Polyic 485
culosis exists. How it May be and has been Cured and Prevented) (rev.)
Rullmore 155
Lynch P P 453 464 472 473 474 513
Lyon D M 582
Lyons A 837
Lyth C E W 459
Lijtil, C. 12. W
M
M.R.C.P. Examinations, Courses
for the
MacCallum, P 485
MacCormick, Sir Alexander 350
Congratulations of Honour of
K.C.M.G 591
Portrait of 317
MacCulloch, S. H 317
Macdonald Colin 348, 417, 587
K.C.M.G
Peanut Impacted in the Right
Bronchus 752
Principles Underlying Treat-
ment by Radium 398
Macdonald, J. G 488
MacDonald, W. J 441, 466
Macdonald, W. Marshall 475, 511
MacGibbon, T. A 465,
Peanut Impacted in the Right Bronchus
MacInnes, A.—
Treatment of Snake Bite 771
MacKeddie, J. F. 435, 452, 454, 471,
511, 512, 658, 659, 928
Macky, A. S 468
Macleod, John James Rickard
(Carbohydrate Metabolism
and Insulin) (rev.) 54
Machamara, Jean 103,
383, 443, 464, 465, 872
MacNell, lan 280
Macpherson, J
Magazar Burent T Burdenum 900
(Carbohydrate Metabolism and Insulin) (rev.) 54 Macnamara, Jean 103, 383, 443, 464, 465, 872 MacNeil, Ian 280 Macpherson, J
Ges Infections of the Ittern
Gas Infections of the Uterus
with Jaundice due to Bacillus • Welchii Following Abortions 787
Magath Thomas P
Magath, Thomas B 725 Maguire, F. A 432
Maguire, F. A
Maguire, F. A
on Sections and Dissections of
a Series of Sixteen Female Pelves
Major I D 700 700
Major, J. P
Malarial Therany-
By Eric Susman 806
By Eric Susman 906 In General Paralysis, by Reg. S. Ellery
S. Ellery 647
35 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Malformations, Congenital 99
and the constitution of th
Malignant Disease, Professor Blair
Bell's Lead Treatment of, by
Brian H. Swift 812, 834 Malignant Disease of the Skin 489
mangiant Disease of the Skin 489

P
Maori, The Coming of the 427
nancy A20
Marchant, E. L 431, 475, 483
Quinine Tolerance and Pregnancy
James W. Barrett 628
James W. Barrett
Massage, Medical Gymnastics and
Medical Electricity, A Guide
to Anatomy for Students of, by E. D. Ewart (rev.) 156
Mastoid Diseases, Operative Treat-
ment of the 482 Materia Medica and Prescription
Writing, Practical, by Oscar
W. Bethea (rev.) 156 Maternal Deaths 204 Maternal Mortality and Morbidity
Maternal Mortality and Morbidity
in Victoria Interim Report
Maudsley, H. F 385,
442, 467, 511, 512, 624, 625, 762, 836
on, by R. Marshall Allan . 1 Maudsley, H. F 385, 442, 467, 511, 512, 624, 625, 762, 836 Maxwell, I
201, 110, 30, 103, 104, 100, 100
McArthur, G. A. D 869
Treatment of Chronic Otorrhea by Zinc Ionization, The 818 McCallum, F. and J. P. Dwyer— Dengue as a Cause of Death 10
McCallum, F. and J. P. Dwyer—
Dengue as a Cause of Death 10
McCoy, H. A 458 McCrae, Thomas 308 Osler's Medicine, Vol. III. (rev.) 409
Osler's Medicine, Vol. III. (rev.) 409
McCutcheon, Alan B 62 McDonald, S. F 130 McDowall, Val 167, 657 McGavin, Sir Donald J 432, 448 McGey J. D
McDowall, Val 167, 657
McGavin, Sir Donald J 432, 448
McGillivray, W. S.—
Typhus-like Epidemics of Aus-
tralia, The: Preliminary Communication 743
McIndoe, A. H 276
McKay, Stewart-
Red-Backed Spider Bite, The 626
Wanted: Ticks 32
McKibbin, T 459, 487, 514, 519 McLaglan, Baker 429, 487 McLaren, W. W 870, 871, 872 McLaughlin, A. I. G. (Diseases of
McLaren, W. W 870, 871, 872
McLaughlin, A. I. G. (Diseases of the Heart and Lungs: A
Handbook for Nurses) (rev.) 826
McLean, J. B 656 McLorinan, Henry 586, 588, 762
McLorinan, Henry 586, 588, 762
Management of Whooping Cough in Hospital 569
McMeekin, R. P 385, 386, 762, 763
Pathology and Clinical Features
of Influenza 750 McPherson, J 442
Meade, F. J
Meaker, Samuel Raynor (Mother
and Unborn Child: A Little Book of Information and Ad-
vice for the Prospective
vice for the Prospective Mothers) (rev.) 792
Medical Appointments 34, 68, 208, 286, 320, 356, 422, 490, 526, 594, 630,
666, 702, 736, 772, 808, 842, 876, 910, 931
Important Notice. 34, 68, 104, 172, 208, 254, 286, 320, 356, 390,
172, 208, 254, 286, 320, 356, 390,
422, 490, 526, 560, 594, 630, 666, 702, 736, 772, 808, 842, 876, 910, 931

XV.

Nei

Net Net A

Net

Ne Ne Ne

Ne

Ne

Ni Ni

Ni

Paga	• Page.
Medical Appointments—Continued.	Melbourne Padiatric Society.
Vacant, etc 34, 68, 104,	The 62, 98, 382, 870
172, 208, 254, 286, 320, 356, 390,	Annual Report 870
422, 490, 526, 560, 594, 630, 666,	Election of Office-Bearers 870
702, 736, 772, 808, 842, 876, 910,	Melbourne Permanent Committee for Post-Graduate Work—
Medical Association of Australia, by E. S. Meyers 170	Lectures by Dr. Allen Kanavel
Medical Benevolent Association	and Dr. Charles Elliot 172, 805, 929
of New South Wales, Report	Winter Course in Obstetrics 805, 929
of New South Wales, Report and Financial Statement 770	Memory, Defective, Absentminded-
Medical Cases, Finlayson's Clini-	ness and their Treatment, by Arnold Lorand (rev.) 756
cal Manual for the Study of, edited by Carl H. Browning,	Mendel and Genius—
E. P. Cathcart and Leonard	By H. B. Oxenham 170, 525
	By G. H. Taylor 355
Findlay (rev.) 613 Medical Curriculum of the Uni-	Mendelson, R. W 759
versity of Melbourne, Report	Meningitis, Cerebro-Spinal 102 Mental Defectives, The Education
on the, by R. J. A. Berry 28, 64 Medical Defence Association of	
Tasmania, The 872	and After Care of 466 Mental Deficiency 101, 581
Election of Office-Bearers 873	Causes and Characteristics, by
Financial Statement 873	John Bostock 325
Medical Defence Society of Queens-	Its Mental and Physical Char-
land, The 205	acteristics, by John Bostock 255 (Leading Article) 341, 581
Annual Meeting 205 Financial Statement 205	Mental Disease—
MEDICAL JOURNAL OF AUSTRALIA 590	Early, by a Group of Well-
Medical Prizes—	Known Authorities (rev.) 410
Alvarenga Prize, The 104	Pathology of, The 441
Gifford Edmonds, The, in	Mental Disorder, Social Aspects of
Ophthalmology 285 Medical Profession in Australia,	of
	Study of, by J. R. Lord (rev.) 375
The	Mercer, W. B 447, 521 Mercury Vapour Lamp, The
Privy Council, The, Special	Mercury Vapour Lamp, The
Report on Social Conditions	Quartz: Its Possibilities and Uses in Public Health and
and Acute Rheumatism 694 Medical Sciences Club of South	General Practice, by J. Bell
Australia, The 251, 872	Ferguson (rev.) 510
Medical Services in the Field 432	Merrillees, Jas. F., Fracture of the
Medical Societies—	Clavicle 33
Alfred Hospital Clinical Society,	Metabolism, Basal, by H. S. Halcro Wardlaw 506
The	Wardlaw 506 Metabolism, Diseases of (Vol. III.
ciety, The 656	of Osler's Medicine) (rev.) 409
Medical Defence Association of	Meyer, K. A
Tasmania, The 872	Meyers, E. S 130, 656, 869
Medical Defence Society of	Medical Association of Australia
Queensland, The 205 Medical Sciences Club of South	tralia
Australia, The 251, 872	Midwifery—
Medical Society of Victoria, The 315	Atlas of, An, by Comyns
Melbourne Hospital Clinical So-	Berkeley and Georges M. Dupuy (rev.) 20
ciety, The 384, 624 Melbourne Pædiatric Society,	Dupuy (rev.) 20 Text-book of, A, for Students
The 62, 98, 382, 870	and Practitioners, by R. W.
Newcastle Hospital Clinical So-	Johnstone (rev.) 649
ciety, The 284, 622, 657	Miles, E. H.—
Medical Society of Victoria, The-	Red-Backed Spider Bite, The 353 Milk of Australian Women, The,
Financial Statement 316 Medicine, General (The Practical	by H. S. Halcro Wardlaw 318
Medicina Series edited by	Millard, R. J. 553, 588, 592, 593, 798, 799
Charles L. Mix) (rev.) 614	An Address—
Medicine, Modern: Its Theory and	Workers' Compensation Act:
Practice, by W. Osler and T. McCrae, Vol. III (rev.) 409	Some Medical Aspects 562 Miller, William Snow 649
Medicine Monographs: Vol. IX:	Milles, G 794
Actions and Uses of the Sali-	
cylates and Cinchophen in	Mills, A. E 317, 555, 798
Medicine, by P. J. Hanzlik	"Milton" 931
Medicine, by P. J. Hanzlik (rev.) 686 Medicine 55	Mind and Its Disorders: A text- book for Students and Practi-
Medicine	tioners of Medicine, by W. H.
William R. Jack (rev.) 861	B. Stoddart (rev.) 510
Meehan, A. V 166, 657	Mind in Disease, The: Some Con-
Melanosis and Cancer of the Bowel 197	ditions Cured by Suggestion,
Melanotic Growth, Bilateral, of Suprarenal Gland, by R. M.	by M. P. Leahy (rev.) 156
Smith 683	Minogue, S. J 442, 467, 478, 556
Smith	Mitchell, Leonard J. C 475, 488
ciety, The 384, 624	Mitral Regurgitation 282

Prolitation Society	age.
Melbourne Pædiatric Society, The 62, 98, 382, Annual Report	870
Annual Report	870
Election of Office-Bearers	870
Melbourne Permanent Committee for Post-Graduate Work—	
Lectures by Dr. Allen Kanavel	
and Dr Charles Elliot 172, 805.	929
Winter Course in Obstetrics 805, Memory, Defective, Absentminded- ness and their Treatment, by	929
ness and their Treatment, by	
Arnoid Lorand (rev.)	756
Mendel and Genius-	595
By H. B. Oxenham	355
Mendelson, R. W	759
Montal Defectives The Education	
and After Care of Mental Deficiency 101,	466
Mental Deficiency 101,	581
Causes and Characteristics, by	
Its Mental and Physical Char-	
acteristics, by John Bostock	255
(Leading Article) 341,	581
Early by a Group of Well-	
Known Authorities (rev.)	410
Pathology of, The	441
(Leading Article) 341, Mental Disease— Early, by a Group of Well- Known Authorities (rev.) Pathology of, The Mental Disorder, Social Aspects of	467
Mental Disorders, The Clinical	10.
Study of, by J. R. Lord (rev.)	375
Mercer, W. B 447,	521
Quartz: Its Possibilities and	
Uses in Public Health and	
General Practice, by J. Bell	510
Merrillees, Jas. F., Fracture of the	910
Clavicle	33
Metabolism, Basal, by H. S. Halcro	FOG
Metabolism, Diseases of (Vol. III.	900
of Osler's Medicine) (rev.)	409
Meyer, K. A	653
General Practice, by J. Bell Ferguson (rev.) Merrillees, Jas. F., Fracture of the Clavicle Metabolism, Basal, by H. S. Halcro Wardlaw Metabolism, Diseases of (Vol. III. of Osler's Medicine) (rev.) Meyer, K. A. Meyers, E. S. Medical Association of Australia Michod, F. A. Hope Midwifery— Atlas of, An, by Comyns	000
tralia	170
Michod, F. A. Hope	622
Midwifery— Atlas of, An, by Comyns Berkeley and Georges M. Dupuy (rev.) Text-book of, A, for Students and Practitioners by R W	
Berkeley and Georges M.	
Dupuy (rev.)	20
and Practitioners, by R. W.	
and Practitioners, by R. W. Johnstone (rev.)	649
Red-Backed Spider Bite, The Milk of Australian Women, The, by H. S. Halcro Wardlaw Millard, R. J. 553, 588, 592, 593, 798,	393
by H. S. Halcro Wardlaw	318
Millard, R. J. 553, 588, 592, 593, 798,	799
Workers' Compensation Act:	
Some Medical Aspects	562
Milles, G	794
Mills, A. E 317, 555,	
"Milton"	931
Mind and Its Disorders: A text- book for Students and Practi-	
tioners of Medicine, by W. H.	
B. Stoddart (rev.)	510
Mind in Disease, The: Some Conditions Cured by Suggestion, by M. P. Leahy (rev.)	
by M. P. Leahy (rev.)	156
Minogue, S. J 442, 467, 478,	556
Mitchell, Leonard J. C 475,	488
Mitral Degranditation	900

Lisa III
Page Page
cine Series: General Medi-
cine) (rev.) 614
Molesworth, E. H 923
Leprosy 387
Radiation Therapy 593
Radiotherapy 701
Rodent Ulcer 878
Mollison, C. H 315
Radiotherapy
Death of 286, 352 Moore, A. P. R
Factore Influencing Extraction
of Teeth
Moore, E. Brettingham 556, 728
An Address 527
Moore, J. I 660
Moore, S. A 442, 447, 467, 519
Moppett, W 486
Convenient Method of Growing
Moore, J. I
Morey M P
Morgan A M
Morbid Anatomy
Morgan, F. C
Morgan, Idris 622
Hypnotic Suggestion 85
Morgan, J. Douglas (Electro-
Morgan, F. C
(rev.) 376
Morkane, C. F 438, 439
Morphology 127
Morris, J. Newman 283, 517, 520,
(rev.)
Morrison, R. H 418 Mosquito Control, The Biological Side of, by R. Hamlyn Harris 108, 130 Mother and Unborn Child: A
Side of, by R. Hamlyn
Harris 108, 130
Mother and Unborn Child: A
Little Book of Information
and Advice for the Prospec-
tive Mother, by Samuel Ray-
Little Book of Information and Advice for the Prospec- tive Mother, by Samuel Ray- nor Meaker (rev.)
Mothers and Children's Nurses,
W. Sauer (rev.) 685 Moynihan, Sir Berkeley (Abdominal Operations) (rev.)
inal Operations) (rev) 124
Muir. Robert 864
Multiglandular Enlargement 280
Murphy, A. P 656
Murrell, William (What to Do in
Cases of Poisoning) (rev.) 580
Murrell, William (What to Do in Cases of Polsoning) (rev.) 580 Muscle Tone
Muscle, Denervated, The Effect of
Galvanism in the Treatment of, by Norman D. Royle 409 Myelitis
Myolitia Norman D. Royle 409
Myclitis 282
Myelomata, The Treatment of 345
Myers, D. F 457, 468, 469, 489, 513
NY.
N
Nævi. Vascular 102
Nævus, Linear 102
Narcolepsy, Idiopathic 624
Nasal Accessory Sinuses, Patho-
logy and Treatment of the In-
roby and ricacinent of the In-
flammatory Diseases of the, by M. Hajek (rev.) 192

Nathan, Charles 143

Naval and Military—
Appointments. . . . 169, 319,
355, 628, 875, 909
Lectures for Officers of the Australian Army Medical Corps. . 33

ĩ.

age.

131

39 27

3

Page.	Page.	Page.
Neil, J. H. Hardie 432, 440, 441, 466,	Ohitman	Original Articles-Continued.
476, 477, 483, 484, 515 Neoplasm, Suprapituitary 624	Obituary— Bower, Reginald Francis 208	Autogenous Vaccines in Infec- tions of the Respiratory
Nervous Disease in Childhood,	Brummitt, Robert 208	Tract, by Leslie Utz and A. J.
Some Modifications of 697 Neuralgia, Trigeminal 386, 836	Bull, Richard Joseph 735, 838 Fiaschi, Thomas Henry 665, 732	Fitzgerald
Neuritis 165	Finlay, Sinclair 254, 352	trol, The, by R. Hamlyn
Alcoholic Peripheral 165	Monson, Robert Bernard Pear-	Harris 108
Optic, as a Complication of Whooping Cough, by G. H.	Parker, Arthur Frederick 931	Biomicroscopy of the Surface Capillaries in Normal and
Hogg 825, 834 Retrobulbar, Associated with	Petrie, James Matthew 769	Pathologic Subjects, by George
Retrobulbar, Associated with Sphenoidal and Ethmoidal	Scott, Leslie John 254, 387 Stanley, Henry Riddell 320, 419	E. Brown and Grace M. Roth 499 Blood Pressure in the Leg in
Sinusitis, by James Flynn 543	Symons, Marc Johnston 420	Aortic Regurgitation, by Eric
Neurology 58	Todd, Arthur Charles Robert 525	F. Gartrell 642
Newcastle Hospital Clinical So-	O'Brien, D. P.— Snake Bite 909	Carcinoma of the Stomach, Gastric Ulcers and Duodenal
ciety, The 284, 622, 657	Obstetrical Research 1, 23	Ulcers in One Thousand Con-
New Guinea, Medical Experiences in 872	Obstetrical Treatment— Report on the Standardization	secutive Autopsies at the
in	of 200	Adelaide Hospital, by J. Burton Cleland 740
448, 477, 728	Cæsarean Section 204	Chemiotaxis in Tissue Culture,
Newton, Alan 96, 384, 385, 386, 620, 624	Eclampsia 201 Hæmorrhage, Accidental 203	by W. Moppett 336 Cholecystitis and its Complica-
Cholecystitis and its Complica-	Hyperemesis Gravidarum 202	tions, by Alan Newton 69
tions 69	Labour—	Cholecystography, by J. G. Edwards
tions 69 Newton, W. S 620, 621 Nitrous Oxide and Oxygen	Abnormal 202 Normal 201	wards 78 Clinical and Radiological Diffi-
(Anæsthesia and the Newer	Ophthalmia Neonatorum 202	culties in the Diagnosis of
Anæsthetics) 599 New South Wales Public Medical	Placenta Prævia 204 Toxæmia, Preeclamptic 202	Lesions of the Prepylorus and Posterior Gastric Wall, by H.
Officers' Association, The 418	Standardization of—	B. Devine 330
New Year Honours 103	By J. B. Dawson 557	Convenient Method of Growing Chick Tissues in Vitro, A, by
Nickel, A. C	By Mary C. de Garis 664 By A. C. F. Halford 664	W. Moppett 335
Nicol, P. M 523	Obstetrics 89	Critical Survey of the Anatomy
Nisbet, A. T.— Acute Pulmonary Tuberculosis	Edgar's Practice of, by J. Clifton Edgar (rev.) 340	of the Female Pelvis, A, Based on Sections and Dissections
in Base of Right Lung 755	Post-Graduate Course in (Mel-	of a Series of Sixteen Female
Nitrous Oxide and Oxygen (Anæs- thesia and the Newer Anæs-	bourne) 805, 929 Present Position of, The 438	Pelves, by F. A. Maguire 173, 209 Dengue as a Cause of Death, by
thetics), by W. S. Newton 599, 620	The Future of, by R. Marshall	F. McCallum and J. P. Dwyer 10
Noble, Ralph 484, 555, 798, 799	Allan 912	Dental Extraction in its Rela-
Noblesse Oblige (Leading Article) 757 Norris, F. Kingsley 62, 587	Occipito-Posterior Positions, Low Transverse Arrest of the Fœtal	tion to Surgery, by Leonard C. E. Lindon 111
Dr. William Palmer, the	Head, by Cecil Coghlan 52	Differences Between the Infec-
Poisoner	Ophthalmia Neonatorum 202 Ophthalmic Cases, Some, by J. C.	tive Larvæ of the Hookworms of Man, The, by G. M. Heydon 531
North, H. M 442, 467	Douglas 609	Difficult Child, The, by John
Notes on Books—	Ophthalmic Science, Contributions	Bostock 704
Ten Weeks with Chinese Ban- dits, by Harvey J. Howard 686	to, Dedicated to Dr. Edward Jackson (rev.) 274	Diseases of the Colon: The Surgical Aspect, by J. C.
Notices 284, 356, 593, 837, 876	Ophthalmology 93	Storey 917
Nott, H. C	Gifford Edmonds Prize in, The 285 Teaching of, The 475	Dr. William Palmer, the Poison-
Powerful Diuretic in the	Opium Traffic 907	er, by F. Kingsley Norris 604 Effect of Galvanism in the
Œdema of Cardiac Failure, by A. E. Rowden White and	Optician, The Prescribing 455	Treatment of Denervated
David Zacharin	Opticians, Association of Dispensing 869	Muscle, The, by Norman D. Royle 409
Nucleic Acid and the Human	Organization in War, Medical 443	Empyema in Adults: The Re-
Organism 872 Nurse, The School, and the Pub-	Original Articles—	sults of an Analysis of the
lic Health 439	Address on Lord Lister, by C. E. Goddard 850	Records of Empyemata Treated
Nurses—	Ætiology and Treatment of In-	at Melbourne Hospital, 1919- 1924, by J. R. Williams 710
Elementary Hygiene for: A Handbook for Nurses and	fantile Eczema, The, by Frank	Epilepsies of Childhood, by A.
Others, by H. C. Rutherford	Trinca	W. Campbell 774
Darling (rev.) 861	æsthetics-	Epilepsy in Childhood, by Guy
Unqualified (Leading Article) 411	Ether, by Reginald Howden 596 Ethylene and Oxygen, by G.	P. U. Prior
Nursing, Practical, for Male Nurses in the R.A.M.C. and	Leonard Lillies 601	thetics and Their Introduction
Other Forces, by E. M. Has-	Intratracheal Administration	to Australia and Tasmania,
sard (rev.) 722	of Ether, the, by F. W. Green 598	An, by Norman J. Dunlop 141
Nuthall, Tallent, and Herbert French (Medical Laboratory	Nitrous Oxide and Oxygen, by	Experiences Abroad, with Spe- cial Reference to Infant Wel-
Methods and Tests) (rev.) 580	W. S. Newton 599 Argyll-Robertson Pupil, the: A	fare, by Vera Scantlebury 35
Nyulasy, Frank A.—	Contribution Towards its	Eye Diseases of Dietetic Origin:
Anatomy of the Female Pelvis,	Explanation, by Herbert J. Wilkinson 267	With Notes on a Case of Oph- thalmia, by S. J. Cantor 822
The 354, 627	WIRINSON 201	mainia, by S. J. Cantoi 622

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Page.	Page.	Page.
Original Articles-Continued.	Original Articles-Continued.	Original Articles-Continued.
Factors Influencing the Extrac-	Pathology and Clinical Features	Treatment of Chronic Otorrhea
tion of Teeth—	of Influenza, by R. P. Mc-	by Zinc Ionization, by G. A.
By A. P. R. Moore 113	Meekin 750	D. McArthur 818
By Leonard Trott 109 Food Supply for Natives in the	Pellagra: A Clinical Study, with Notes on Some Cases, by S. J.	Treatment of Congenital Spastic Paraplegia by Sympathetic
Territory of Papua, by W. M.	Cantor 713	Ramisection, by N. D. Royle. 632
Strong 607	Pertussis, by Robert Southby 564	Treatment of Hiccup Occurring
Gravimetric Determination of	President's Address—	During Anæsthesia, by S. J.
Basal Metabolism, The, by H.	By E. Brettingham Moore 527	Cantor 858
S. Halcro Wardlaw 506	By R. J. Millard 562	Treatment of Peritonitis, The,
Head Injuries, by T. E. Lambert 671	Principles Underlying Treat-	by W. R. Groves 260
Hospital Question in New South	ment by Radium, by Colin	Treatment of Thyreoid Enlarge-
Wales, The, by Thomas Hamil-	Macdonald 398	ment Including Exophthalmic
ton	Professor Blair Bell's Lead	Goître by Injections of Quinine and Urea Hydrochloride into
The, by David D. Browne 677	Treatment of Malignant Disease, by Brian H. Swift 812	the Thyreoid Gland, by H.
Hospital Practice, by A. E.	Prostatectomy and its After	G. Loughran 263
Brown 292	Results, by J. T. Tait 571	Two Intussusceptions Alternat-
Brown	Psychoses of the Puerperium, by	ing with Two Adenomata of
Forsyth 407	Reg. S. Ellery 287	the Small Bowel, by F. W. D.
Influenza—	Public Health in Greater Bris-	Collier 81
By J. P. Major 744	bane, by H. W. Tilling 105	Typhus-Like Epidemics of Aus-
Its Epidemiology and Preven- tion, by Frank R. Kerr 747	Puerperal Infection, by H. A.	tralia, The: A Preliminary Communication, by W. S. Mc-
Interim Report on Maternal	Ridler	Gillivray 743
Mortality and Morbidity in	of the Colon, The, by J. G.	Workers' Compensation Act.
Victoria, by R. Marshall Allan 1	Edwards 916	1926: Some Medical Aspects,
Interpretation and Clinical Sig-	Radiotherapy: Why is This	by R. J. Millard 562
nificance of Certain Electro-	Form of Treatment Not More	X Ray Examination of the
cardiograms, The, by Eric F.	Generally Employed? by H.	Stomach, by H. M. Hewlett 328
Gartrell 528 Joint Tuberculosis, by Russell	Flecker 302	Orthopædic Surgery 92 In America 166
A. Hibbs and Alan De F.	Random Urological Notes, by Glen H. Burnell 815	Osborn, C. H 625
Smith 810	Recollections and Impressions	Osborne, Ethel 871, 872
Lister Centenary Oration, by J.	After Twenty-Four Years of	Osler's Medicine, Volume III (rev.) 409
Lockhart Gibson 844	Country Practice, by W. R.	Osteitis Deformans 164
Lister Oration: The Future of	Groves 265	"Ostelin" 756
Obstetrics, by R. Marshall	Relations of Temperature and	Osteo-Arthritis
Allan 912 Low Transverse Arrest of the	Pulse Rate in Disease, The: A Clinical Study, by D. W.	Osteogenesis Imperfecta
Fœtal Head in Occipito-Pos-	Carmalt Jones 491	
terior Positions, by Cecil	Review of the Diabetes Question,	Otani, Sadao 617 Otitis Media and Diplopia 869
Coghlan 52	A, by Basil Corkill 46	
Management of Whooping Cough	Rodent Ulcer, by E. H. Moles-	Oto-Rhino-Laryngology 125
in Hospital, by Henry Mc-	worth 878	Otorrhea, Chronic, The Treatment
Lorinan 569 Mental Deficiency: Causes and	Scar in Cæsarean Section, The:	of, by Zinc Ionization, by G. A. D. McArthur 818
Characteristics, by John Bos-	With Report of Two Cases of Rupture of the Uterus, by	Owen-Johnston, A 467, 468, 478
tock 325	Constance E. D'Arcy 333	
Mental Deficiency: Its Mental	Simplification of the Dietetic	Oxenham, H. B.— Mendel and Genius 170, 525
and Physical Characteristics,	Treatment of Diabetes Melli-	_
by John Bostock 255	tus, by R. Coupland Winn 321	Oxycephaly 284
Nasal Polypi, by W. Sangster 154	Some Bad Results of Gynæco-	P
Notes on the Probable Life of Cercaria Catellæ, an Echino-	logical Operations, by R. I.	
stome Cercaria from New	Furber	Packard, Francis R. (Guy Patin
South Wales, by Burton	Settlement at the River Der-	and the Medical Profession in
Bradley 673	went (1803-1805), by William	Paris in the XVIIth Century)
Observations on Certain Thera-	L. Crowther 370	(rev.) 755
peutic Measures in Dermato-	Stammering as a Psychoneurosis:	Pædiatrics 90
logical Practice, by W. Upton 715 On Irritable Ulcer of the Leg, or	A Plea for Corrective Meas-	Paget, T. L 430
Malleolus, and its Cure by	ures, by T. Garnet Leary 299	Paget's Disease of the Nipple 864
Operation, by C. E. Corlette 782	Suicide, by W. A. T. Lind 679	Palmer, A. A 419
Operation for Bunion, by G. A.	Summary of Radium Treatment	Snake Bite 873
Hagenauer 787	at the Women's Hospital, Mel-	Palmer, Dr. William, the Poisoner,
Operative Treatment of Hirsch-	bourne, During the Last Five	by F. Kingsley Norris 604
sprung's Disease, The: A New	Years, by W. D. Saltau 403	Palmer, H. W 458, 459
Method, by R. B. Wade and	Syphilis in Children, with Spe-	Pancreas, The Islands of Langer-
Norman D. Royle 137	cial Reference to the Efficiency of Bismuth for Treatment, by	hans in the Human 617
Paragonimiasis: Its First Re-	Robert Southby 357	Pancreatitis 412
corded Occurrence in the Ter-	Teaching of Hygiene in Schools,	Paradice, W. E. J 443
ritory of New Guinea, by R.	The, by Harvey Sutton 668	Paragonimiasis 454, 481
W. Cilento and T. C. Back-	Tonsillectomy With the Guillo-	Its First Recorded Occurrence in
house 79	tine, by Clive M. Eadie 676	the Territory of New Guinea,
Pathological Lesions Present in One Thousand Consecutive	Treatment of Acute Suppurative	by R. W. Cilento and T. C.
Autopsies in the Adelaide	Arthritis of the Knee Joint,	Backhouse 79
Hamital by T Duntan Claland 790	by Balcombo Quick 201	Paralysis Spastic 484

ge.

Page.	Page.	Page.
Paraplegia-	Physiology of the Continuity of	Pryde, Alan—
Complicating Pott's Disease 834	Life, The, by D. Noël Paton	and W. P. Holman-
Spastic 281, 284	(rev.) 88	Perthes's Disease 753
Treatment of Congenital, The,	Physiotherapy, A Practice of, by	Ileal Intussusception in an
by Sympathetic Rami-	C. M. Sampson (rev.) 546	Adult 648
section, by N. D. Royle 632	Pickerill, H. P 446, 447, 465	Pseudo-Hermaphroditism Occur-
Parasitology in the Tropics 480	Pickett-Thomson Research Labora-	ring in Two Children of the
Park, W. H 244	tory, Annals of the, Vol. II	One Family, by Wolfe Davis 860 Pseudo-Myxoma Peritonei of
Parker, Arthur Frederick, Death of 931	(rev.) 721	Appendiceal Origin and
Parker, R. A.—	Piness, G	Mucocele of the Appendix, by
Hypnotic Suggestions 354	Plague 660	J. B. Cleland and J. G.
Snake Bite 930	Pneumonic 378	Sleeman 721
	Plaster Bed, Construction of a 835	Psychiatry 58
Parotid Swelling 99	Pneumonia, Unresolved 872	University Teaching of 467
Paterson, Ada 439, 470, 516	Pneumo-Thorax, Artificial 471	Psychoses of the Puerperium, by
Paterson, Donald and J. Forest	Poate, H. R. G 484	Reg. S. Ellery 287
Smith (Modern Methods of	Pockley, F. Antill 431, 432	Public Wedies Officers Assessed
Feeding in Infancy and Child-	Pockley, Guy Antill and V. M.	Public Medical Officers' Associa- tion, The New South Wales 418
hood) (rev.) 340	Coppleson—	Puerperal Fever 662
Pathological—	Rodent Ulcer of the Lower Eye-	The Therapy of, by Robert
Investigations	lid Treated by Diathermy 241	Koehler (rev.) 242
Pathology	Poisoning, What to do in Cases of, by William Murrell (rev.) 580	Puerperal Infection, by H. A.
Comparative 472	Poliomyelitis 103, 463, 927	Ridler 118, 133
Patin, Guy and the Medical Pro-	Acute Anterior 164	Pugh, William Russ 144
fession in Paris in the XVIIth	Streptococcus in, The 549	Pulleine, R. H 440, 466, 483, 515, 516
Century, by Francis R.	Pollock, E. F 807	Pullen, E. D 485
Packard (rev.) 755	Polyarthritis 836	Pulse Rate and Temperature, The
Paton, D. Nöel (Physiology of the	Polypi, Nasal, by W. Sangster 154	Relations of in Disease: A
Continuity of Life) (rev.) 88	Polyuria in Rats, Artificial 251	Clinical Study, by D. W.
Pattin, H. Cooper 470, 522	Porter, Miles F 197	Carmalt Jones 491 Pulse Rate to Temperature, The
Peanut Impacted in the Right	Post-Graduate Work 23,556,908 Course in Brisbane735	Relation of 582
Bronchus, by J. M. Baxter and		Pupil, The Argyll-Robertson: A
Colin Macdonald 752	Course in Tropical Medicine and	Contribution Towards its
Pearson, A. B 453, 464, 473, 474 Pellagra: A Clinical Study, with	Tropical Hygiene 421 Courses in Berlin 769	Explanation, by Herbert J.
Notes on Some Cases, by S. J.	Lectures in Launceston 928	Wilkinson 267, 525
Cantor 713	Melbourne Permanent Com-	Wilkinson 267, 525 Purdy, J. S 433, 444, 476, 478, 514
Pelvis, Female—	mittee for 172, 805, 929	British Medical Association, The
A Critical Survey of the	Post Mortem Examination Fees in	and Medical Officers 171
Anatomy of the, Based on	Western Australia 665	Purpura Hæmorrhagica—
Sections and Dissections of a	Pottinger, J. A 445, 521	By Henry Shannon 241
Series. of Sixteen Female	Pott's Disease 285	With Retinal Hæmorhages 610 Purser, Cecil
Pelves, by F. A. Maguire 173, 209	Poynton, F. J 685	Purser, Cecii
The Anatomy of the, by Frank	Praagst, H. F 457, 489	Q
A. Nyulasy 354, 627	Practitioners, State and Hospitals,	
Pennington, Geoffrey A 101,	The Relationship Between 517 Pregnancy—	"Quackery"—
Peritonitis, The Treatment of, by	Ectopic, in Three Sisters, by	By Guy P. U. Prior 252 By Arthur S. Vallack 67
W. R. Groves 260, 283	William L. Crowther 610	Queensland, Report of the Com-
Perla, David 830	Obstruction of the Ileum in, by	mission of Public Health 660
Pern, Sydney—	F. C. Burke-Gaffney 577	Quick, Balcombe 96, 416
Focal Infections 67	Quinine and, by L. Crivelli 354	Treatment of Acute Suppurative
Snake Bite 874	Quinine Tolerance and—	Arthritis of the Knee Joint,
Perry, Charles	By K. St. V. W 253	The 391
	By Laurence H. Hughes 421	Quinine—
liminary Dietetics, A) (rev.) 861 Perthes's Disease, by Alan Pryde	By Philip A. Maplestone 420 Prescott, J. A	And Pregnancy— By L. Crivelli 354
and W. P. Holman 753	Preventive Medicine 24	Bureau for Increasing the Use
Pertussis, by Robert Southby 564, 586	Price, W. L 523	of (Chininum Scriptiones
Pes Cavus 99	Prior, Guy P. U 441,798	Collectæ Anno MCMXXIV
Petersen, William F 794	Epilepsy in Childhood 775, 841	Editæ) (rev.) 686
Pétridis, Pavlos, et A. Valasso-	"Quackery" 252	Tolerance and Pregnancy—
poulos (Les Hépatites Dysen-	Prizes, Medical—	By Laurence H. Hughes 421
tériques et leur Traitement)	Alvarenga 104	By K. St. V. Welch 253
(rev.) 860	Gifford Edmonds, The, in	By Philip A. Maplestone 420
Petrie, James Matthew 659	Ophthalmology 285	The state of the s
Death of	Professional Confidence 590	R
Conference with Federal Com-	Prolapse, The Treatment of 482 Proprietary Medicines, by Phar-	Radcliffe-Taylor, Marion A 468, 469
mittee (B.M.A.) 731	maceutical Society of New	Radiation—
Pharmaceutical Society of New	South Wales 252	Therapy, by E. H. Molesworth. 593
South Wales—	Proptosis: Some Interesting Cases,	Ultra-Violet, and Actinotherapy,
Proprietary Medicines 252	by H. M. Jay 119	by Eleanor H. and W. Kerr
Pharmacopæia, British, Revision	Prostate, Hypertrophy of the 835	Russell (rev.) 722
of 731	Prostatectomy—	Radiological—
Physicians, Membership of the	And its After Results, by J. T.	Aspect of the Diseases of the
Royal College of, Edinburgh 663 Physiology 193	Tait 571	Colon, by J. G. Edwards 916 Problems
Physiology 193	Suprapubic 460	Problems 445

Retr Ob Or Or Or Ot Pa Pi Po Pr Ps Ra Ro St

St TI Ui

Page.	Page.	Page,
Radiology 157, 167, 522	Reports of Cases-Continued.	Reports of Cases-Continued.
Development of, The 445	Cyst of the Duodenum Simulat-	Pseudo-Hermaphroditism Occur-
Radiotherapy-	ing Pyloric Obstruction, by K.	ring in Two Children of the
By Archie Aspinall 663, 875	Maddox 900	One Family, by Wolfe Davis 860
By H. Flecker 806	Ectopic Pregnancy in Three	Pseudo-Myxoma Peritonei of Ap-
By E. H. Molesworth 701	Sisters, by William L.	pendiceal Origin and Mucocele
Why is This Form of Treatment	Crowther 610	of the Appendix, by J. B. Cle-
not More Generally Employed?	Exophthalmic Goftre, by O. A. A.	land and J. G. Sleeman 721
by H. Flecker	Diethelm 123	Purpura Hæmorrhagica, by
Radium-	Gas Infection of the Uterus with	Henry Shannon 241
Principles Underlying Treat-	Jaundice Following Abortion,	Purulent Infiltration in and Around the Thyreoid Gland,
ment by, by Colin Mac-	by F. H. Beare and J. B.	by J. Burton Cleland 790
donald 398, 417	Cleland 719	Retrobulbar Neuritis Associated
Treatment at the Women's Hos-	Gas Infections of the Uterus	with Sphenoidal and
pital, Melbourne, During the	with Jaundice due to Bacillus	Ethmoidal Sinusitis, by James
Last Five Years, Summary of,	Welchii Following Abortions,	Flynn 543
by W. D. Saltau 403, 417	by Rupert Magarey, J. Burton	Rheumatoid Arthritis Treated
Railway, North-South 349 Ramisection—	Cleland and J. G. Sleeman 787	at Paralana Hot Springs,
And Hirschsprung's Disease 554	Gumma of the Interventricular	South Australia, by C. C.
And Visceroptosis, by J. Hoets 525	Septum of the Heart Giving	Fenton 681
Results of, The 554	Rise to Heart Block, by J. Burton Cleland 540	Rodent Ulcer of the Lower Eye-
Sympathetic—		lid Treated by Diathermy, by
By A. R. Southwood 318	Healed Dissecting Aneurysm Giving Rise to the Appearance	Guy Antill Pockley and V. M.
By N. D. Royle 841	of a Double Aorta, by J.	Coppleson
Treatment of Congenital	Burton Cleland 538	by S. Goldberg 611
Spastic Paraplegia, The, by,	Herpes Ophthalmicus, by J. B.	Some Ophthalmic Cases, by J.
by N. D. Royle 632	Lewis 124	C. Douglas 609
Ramsay, J 437	Herpes Zoster and Varicella Oc-	Subacute Bacterial Endocard-
Raymond, R. L 660	curring Simultaneously in the	itis, by G. A. Kaye and N. B.
Raynaud's Disease 472 Recollections and Impressions	Same Person, by R. L. Thorold	White 859
after Twenty-Four Years of	Grant 192	Ulcero-Membranous Stomatitis,
Country Practice, by W. R.	Hypnotic Suggestion, by Idris	by J. Horace Downing 273
	Morgan 85	Unusual Type of Intussuscep-
Groves	Hysterical Fugue, by S. Evan	tion, An, by R. D. McKellar
Red-free Light in Ophthalmoscopy 455	Jones 541	Hall 304
Renal Infections 452	Ileal Intussusception in an Adult, by Alan Pryde 648	Urticaria Pigmentosa in Adults,
Renal Efficiency 454		by K. G. Colquhoun 824 Use of "Novasurol," The, as a
Renal Stone 837	Immuno-Transfusion in Bac-	Powerful Diuretic in the
Renal Surgery, A Handbook of,	terial Endocarditis, by D. D.	Œdema of Cardiac Failure, by
by F. McG. Loughnane (rev.) 545	Browne 578	A. E. Rowden White and
Reports of Cases— Acute Postoperative Dilatation	Left Subclavian Aneurysm: In-	David Zacharin 273
of the Stomach, by Gilbert	trathoracic Ligature, by R. J.	Wandering Endometrioma, by
Brown 542	Wright-Smith 754	Reginald Davies 373
Acute Pulmonary Tuberculosis	Lymphocythæmia, by H. H. Bull- more	Research-
in Base of Right Lung, by A.		Cancer 253, 275, 318
T. Nisbet 755	Malarial Therapy in General	Foulerton Research Studentship,
Amœbic Dysentery Acquired in	Paralysis, by Reg. S. Ellery 647 Mesenteric Cyst Simulating	The 207
North Queensland, by A. H.	Acute Post Partum Dilatation	Fund, The Harmsworth
Baldwin, G. M. Heydon and	of the Stomach, by Alan E.	Memorial
J. A. Broben 374	Lee 83	Science Scholarship 660
Arsenical Neuritis Treated by	Multiple Superficial Scarring	
the Intravenous Injection of Sodium Thiosulphate, by T.	Ulcerations of the Small In-	Respiratory Tract, Autogenous Vaccines in Infections of the,
Dixon Hughes 543	testine and Duodenal Scar	by Leslie Utz and A. J. Fitz-
Bilateral Glioma Retinæ, by C. G.	with Pyloric Obstruction, by	gerald 15
Berge 578	Malcolm Scott and J. B. Cle-	Resuscitation 527
Bilateral Melanotic Growth of	land 718	
Suprarenal Gland, by R. M.	Obstruction of the Ileum in	Retinal Detachment 869
Smith 683	Pregnancy, by F. C. Burke-	Retinitis Pigmentosa 488
Carcinoma of the Right Lung,	Gaffney 577	Retrospect, A21, 55, 89, 125, 157, 193
by H. T. Illingworth 611	Optic Neuritis as a Complica-	Australasian Medical Congress
Case of Concealed Accidental	tion of Whooping Cough, by	(British Medical Association) 24
Hæmorrhage, A, by H. A.	G. H. Hogg 825 Partial Rupture of the Uterus	Australasian Medical Publish- ing Company, Limited, The 25
Ridler	During Pregnancy with Fatal	Bacteriology
Humphrey Lloyd 684	Intraperitoneal Hæmorrhage,	Biological Chemistry 195
Case of Scurvy, A., by E. W.	by J. Burton Cleland 790	British Medical Association, The 21
Frecker 274	Pathology of Two Cases of	Dermatology 158
Case of Systemic Blastomycosis	Sudden Death, The, by Oliver	Gynæcology 58
with the Formation of a	Latham 121	Hygiene 194
Myxomatous Looking Tumour-	Peanut Impacted in the Right	Immunology 159
Like Mass, A, by J. Burton	Bronchus, by J. M. Baxter and	Medical Profession in Australia,
Cleland 337	Colin Macdonald 752	The 21
Chorion Epithelioma, by Con-	Perthes's Disease, by Alan	Medicine 55
stance E. D'Arcy 858 Complicated Dextrocardia, by	Pryde and W. P. Holman 753 Proptosis: Some Interesting	Morbid Anatomy 160
James E. Sherwood 720	Cases, by H. M. Jay 119	Morphology
	Choos of an all out 113	

P	age.
Reports of Cases-Continued.	
Pseudo-Hermaphroditism Occur- ring in Two Children of the	
ring in Two Children of the One Family, by Wolfe Davis	860
Pseudo-Myxoma Peritonei of Ap-	
pendiceal Origin and Mucocele	
of the Appendix, by J. B. Cleland and J. G. Sleeman	721
Purpura Hæmorrhagica, by Henry Shannon Purulent Infiltration in and	
Henry Shannon	241
Around the Thyreoid Gland,	
by J. Burton Cleland	790
Retrobulbar Neuritis Associated	
with Sphenoidal and Ethmoidal Sinusitis, by James	
Flynn	543
Rheumatoid Arthritis Treated	
at Paralana Hot Springs,	
Flynn	681
Rodent Ulcer of the Lower Eye-	
lid Treated by Diathermy, by	
Guy Antill Pockley and V. M.	241
Coppleson	
by S. Goldberg	611
Some Ophthalmic Cases, by J.	609
C. Douglas	000
itis, by G. A. Kaye and N. D.	
White	859
hy J Horace Downing	273
Unusual Type of Intussuscep- tion, An, by R. D. McKellar	
tion, An, by R. D. McKellar	204
Hall	304
by K. G. Colquhoun	824
Use of "Novasurol," The, as a	
Powerful Diuretic in the	
CEdema of Cardiac Failure, by A. E. Rowden White and	
	273
Wandering Endometrioma, by Reginald Davies	373
Research—	010
Cancer 253, 275,	318
Foulerton Research Studentship,	007
The	207
Memorial	379
Memorial	1, 23
Science Scholarship	600
Respiratory Tract, Autogenous Vaccines in Infections of the,	
by Leslie Utz and A. J. Fitz-	
gerald:	15
Resuscitation	527
Retinal Detachment	869
Retinitis Pigmentosa	488
Retrospect, A 21, 55, 89, 125, 157 Australasian Medical Congress	, 193
(British Medical Association)	24
Australasian Medical Publish-	0.5
ing Company, Limited, The Bacteriology	25 159
Biological Chemistry	195
British Medical Association. The	21
Dermatology	158
Gynæcology	58 194
Immunology	159
Medical Profession in Australia.	01
The	21 55
Medicine	160
Morphology	127

ge.

p	age.	· p	age.	P	age
Retrospect—Continued.	ago.	Reviews-Continued.	ugo.	Reviews-Continued.	ugo
Obstetrical Research	23	Diseases of the Intestines, by		Inflammatory and Toxic Dis-	
		A. P. Cawadias		eases of Bone, The: A Text-	
Obstetrics		Diseases of the Skin, by James		book for Senior Students, by	
Orthopædic Surgery		H Sequeire	613	R. Lawford Knaggs	546
Oto-Rhino-Laryngology		H. Sequeira	010	Insects of Australia and New	010
Pædiatrics	90	Possibilities, by Max Einhorn	306	Zealand, The, by R. J. Till-	
Physiology	193			yard	826
Physiology	23	Early Mental Disease, by a		1	020
Preventive Medicine	24	Group of Well-Known Author-		Lectures on Diseases of Child-	
		ities, The Lancet Extra Num-		ren, by Robert Hutchison	375
Psychiatry		bers, No. 2		Life and Time of Adolf Kuss-	
Research, Obstetrical		Edgar's Practice of Obstetrics,		maul, The, by Theodore H.	
Surgeons of Australasia, The	20	by J. Clifton Edgar		Bast	649
	25	Electrothermic Methods in the		Light Treatment in Surgery, by	
College of		Treatment of Neoplastic Dis-		O. Bernhard	88
Surgery	89	eases, by J. Douglas Morgan		Manual in Preliminary Dietetics,	
Therapeutics		Elements of Medical Treatment,		A, by Maude A. Perry	861
		The, by Robert Hutchison	375	Manual of Surgery for Students	
Urology	120	Elementary Hygiene for Nurses:		and Practitioners, by Albert	
Reviews—	1	A Handbook for Nurses and		Carless (Eleventh Edition)	340
Abdominal Operations, by Sir		Others, by H. C. Rutherford		Medical Case Taking: A Guide	-
Berkeley Moynihan	124	Darling		for Clinical Clerks, by Alex.	
Annals of the Pickett-Thomson		Enzymes: Properties, Distribu-		Mills Kennedy	860
Research Laboratory, Vol. II.		tion, Methods and Applica-		Medical Laboratory Methods	
(Photomicrography and Bac-		tions, by Selman A. Waksman		and Tests, by Herbert French	
teria)	721	and Wilburt C. Davison		and Tallent Nuthall	580
Atlas of Midwifery, An, by		Exophthalmic Goître, by J.	000	Medicine Monographs—	
Comyns Berkeley and Georges	-	Eason		Vol. IX: Actions and Uses of	
M. Dupuy	20	Facts on the Heart, by Richard		the Salicylates and Cin-	
		C. Cabot	376	chophen in Medicine, by P.	
Baillière's Synthetic Anatomy:	- 1	Finlayson's Clinical Manual for		J. Hanzlik	888
A Series of Drawings on		the Study of Medical Cases,		Vol. XII: Immunity in	000
Transparent Sheets for Facili-		Edited by Carl H. Browning,		Syphilis, by Alan M. Chesney	799
tating the Reconstruction of		E. P. Cathcart and Leonard		Mind and Its Disorders: A Text-	104
Mental Pictures of the Human	440	Findlay	613	book for Students and Practi-	
Body, by J. E. Cheeseman	410	Food and the Principles of		tioners of Medicine, by W. H.	
Bergey's Manual of Determinative		Dietetics, by Robert Hutchison	579	P Stoddart	510
Bacteriology: A Key for the	1	Fundamentals of Dermatology,		B. Stoddart	OIV
Identification of Organisms of		by Alfred Schalek	242	Conditions Cured by Sugges-	
the Class Schizomycetes, by		Fundamentals of the Art of Sur-		tion, by M. P. Leahy	156
David H. Bergey	580	gery, by John H. Watson	685	Modern Medicine, Its Theory	190
Carbohydrate Metabolism and		Guide to Anatomy for Students		and Practice, edited by Sir	
Insulin, by John James		of Medical Gymnastics, Mas-		William Osler, re-edited by	
Rickard Macleod	54	sage and Medical Electricity,		Thomas McCrae; Vol. III.:	
Cavernous Sinus Thrombo-		A, by E. D. Ewart	156	Diseases of Metabolism, Dis-	
phlebitis and Allied Septic	1	Guy Patin and the Medical Pro-		eases of the Digestive System	409
and Traumatic Lesions of the		fession in Paris in the XVIIth		Modern Methods in the Diag-	100
Basal Venous Sinuses, by		Century, by Francis R.		nosis and Treatment of Heart	
Wells P. Eagleton	54	Packard		Disease, by Francis Heather-	
Chininum Scriptiones Collectæ		Handbook of Renal Surgery, A,		ley	20
Anno MCMXXIV Editæ, Is-		by F. McG. Loughnane	545	Modern Methods of Feeding in	40
sued by The Bureau for In-		Health: A Textbook for Schools,		Infancy and Childhood, by	
creasing the Use of Quinine	686	by M. Avery	544	Donald Paterson and J. Forest	
Clinical Interpretation of the		Hépatites, Dysentériques et leur		Smith	340
Wassermann Reaction, The,	i	Traitement, Les. par A.		Mother and Unborn Child: A	0.10
by Robert A. Kilduffe	579	Valassopoulo et Pavlos		Little Book of Information	
Clinical Study of Mental Dis-		Pétridis	860	and Advice for the Prospec-	
orders, The, by J. R. Lord	375	Hernia and Hernioplasty, by		tive Mother, by Samuel Ray-	
Compendium of Regional Diag-		Ernest M. Cowell		nor Meaker	793
nosis in Affections of the		High Blood Pressure, its Varia-	-	Normal Child, The, and How to	
Brain and Spinal Cord, by R.		tions and Control: A Manual		Keep it Normal in Mind and	
Bing Ophthalmic	922	for Practitioners, by J. F.		Morals, by B. Sachs	ero
Contributions to Ophthalmic		Halls Dally	545	Nursery Guide for Mothers and	000
Science: Dedicated to Dr. Ed-	1	History Taking and Recording,			
ward Jackson in Honour of		by James A. Corscaden	792	Children's Nurses, by Louis	COE
His Seventieth Birthday by		Hospital Housekeeping and		W. Sauer	000
His Pupils and Colleagues in		Sanitation, by Nora P. Hurst	756	Pathology and Treatment of the	
the United States, 1926	274	Hydrogen Ion Concentration of		Inflammatory Diseases of the	
Defective Memory, Absent-		the Blood in Health and Dis-		Nasal Accessory Sinuses, by	
mindedness and their Treat-		ease, by J. Harold Austin and		M. Hajek	192
ment, by Arnold Lorand	756	Glenn E. Cullen	545	Pernicious Anemia, by Frank A.	
de Lamar Lectures, 1925-1926,		Illustrated Australian En		Evans	305
The, of the School of Hygiene		cyclopædia, The, Edited by		Physiology of the Continuity of	
and Public Health, Johns Hop-		Arthur Wilberforce Jose and		Life, The, by D. Noël Paton	88
kins University, edited by W.		Herbert James Carter: Vol. II.	53	Popular Education in Public	
H. Howell	722	Infant Welfare for the Student		Health, by W. Allen Daley and	
Diseases of the Heart and		and Practitioner, by Hazel H.		Hester Viney	686
Lungs: A Handbook for		Chodak Gregory	510	Practical Materia Medica and	
Nurses, by A. I. G.		Infections of the Hand, by		Prescription Writing, by Oscar	
McLaughlin	826	Lionel R. Fifield	544	W. Bethea	156

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Page.	Page.	Page.
Reviews-Continued.	Rodent Ulcer-	Scapular Types
Practical Medicine Series, The,	By E. H. Molesworth 878	Scarlet Fever 662
General Medicine 614	Of the Eyelid and X Rays, by	Schaeffer, Henri F 413
Practical Nursing for Male	H. Flecker 318	Schalek, Alfred (Fundamentals of
Nurses in the R.A.M.C. and	Of the Face 835	Dermatology) (rev.) 242
Other Forces, by E. M. and	Of the Lower Eyelid Treated by	Schenk, T 660
A. R. Hassard 722	Diathermy, by Guy Antill	Schlatter's Disease 102
Practice of Physiotherapy, A,	Pockley and V. M. Coppleson 241 Rodman's Amputation of the	Schlink, Herbert H 485
by C. M. Sampson 546 Rheumatic Heart Diseases, by	Breast 285	Schwartz, Z 488
Carey F. Coombs 685	Rodway, F. A.—	Schwartz, Z
Quartz Mercury Vapour Lamp,	Red-Backed Spider Bite, The 770	Scoliosis, Static or Postural 837
The: Its Possibilities and Uses	Rosenow, E. C 549	Scott Leslie John-
in Public Health and General	Ross, I. Clunies 548	Death of 254, 387
Practice, by J. Bell Ferguson 510	Cancer Research 253	Scott, Malcolm and J. B. Cleland-
Serum Diagnosis of Syphilis by	Roth, Grace M. and George E.	Multiple Superficial Scarring
Precipitation: Governing Prin-	Brown—	Ulcerations of the Small In-
ciples, Procedure and Clinical	Biomicroscopy of the Surface	testine and Duodenal Scar
Application of the Kahn Pre-	Capillaries in Normal and	with Pyloric Obstruction 718
cipitation Test, by R. L. Kahn 650	Pathologic Subjects 499	Scott, R. J 873 Scudder, Charles Locke (Treat-
Ship-Surgeon's Handbook, The,	Rowan, C. P 837	
by A. Vavasour Elder 649	Rowan, Paul 280	ment of Fractures, The, with
Short History of Anatomy, A, by	Royal Society for the Prevention	Notes upon a Few Common
Richard H. Hunter 826 Studies from the Institute of	of Cruelty to Animals, The 319	Dislocations) (rev.) 791
Modical Personal Kuala	Royle, Norman D 444, 445,	Scurvy, A Case of, by E. W.
Medical Research, Kuala Lumpur, Federated Malay	456, 468, 469, 472, 478, 484, 511, 554	Frecker 274
States, Number 20: Notes on	And R. B. Wade—	Sear, H. R 457, 512, 926
Malayan Culicidæ, by A. T.	Operative Treatment of	Semmens, K
Stanton 827	Hirschsprung's Disease, The:	Sequeira, James H. (Diseases of
Text-Book of Midwifery for Stu-	A New Method 137	the Skin) (rev.) 613
dents and Practitioners, A, by	Effect of Galvanism in the Treat-	Serum, The Toxicity of Human 758
R. W. Johnstone 649	ment of Denervated Muscle,	Sewell, S. V 384, 385, 386, 433
Therapy of Puerperal Fever, The, by Robert Koehler;	The 409	471, 481, 482, 484, 512
The, by Robert Koehler;	Sympathetic Ramisection 841	Sex, Child of Doubtful 871
American Edition by Hugh	Treatment of Spastic Paraplegia	Shannon, Henry-
Ehrenfest 242	by Sympathetic Ramisection, The	Purpura Hæmorrhagica 241
Treatment of Fractures with	The	Shaw, A. F. Bernard 688
Notes upon a Few Common Dislocations, The, by Charles	Backfire Fracture of the Fore-	Shaw, R. M
Locke Scudder 791	arm 355	Sheard, Charles 725
Tuberculosis Hospitalization, by	Russell, Eleanor H. and W. Kerr	Sherwood, James E.— Complicated Dextrocardia 720
Godias J. Drolet 650	Russell (Ultra-Violet Radia-	Ship-Surgeon's Handbook, The, by
Ultra-Violet Radiation and	tion and Actinotherapy)	A. Vayasour Elder (rev.) 649
Actinotherapy, by Eleanor H.	(rev.) 722	Ships' Surgeons 413, 728
and W. Kerr Russell 722	Russell, Eustace 556, 622 Russell, H. H. E 131, 349, 552, 834	A. Vavasour Elder (rev.) 649 Ships' Surgeons 413, 728 Shorney, H. F 431, 432, 441,
Ultra-Violet Rays in General	Russell, H. H. E 131, 349, 552, 834	454, 455, 456, 475, 488, 515
Practice, by W. Annandale	Russell, R. Hamilton 352, 444, 445, 480	Shortland, L. J 660
Troup 614 What to Do in Cases of Poison-	Russell, W. Kerr and Eleanor H.	Shugg, A. W 556
ing, by William Murrell 580	(Ultra-Violet Radiation and Actinotherapy) (rev.) 722	Sieburgh, G 583
Wheeler's Handbook of Medi-	Actinomerapy) (1ev.) 122	Siedeberg, E. H 452
cine, by William R. Jack 861	S	Silberberg, M. D 281, 659
Why Tuberculosis Exists? How	~	Sinclair, D. L 430
it May be and Has Been Cured	Sachs, B. (Normal Child, The,	Sinusitis 514
and Prevented: A Book of	and How to Keep it Normal in	Skiagrams
Facts, by R. Goulburn Lovell 613	Mind and Morals) (rev.) 650	Skin, Diseases of the, by James H.
Rheumatic Heart Disease 870	Salicylates 686	Sequeira (rev.) 613
Rheumatic Heart Diseases, by	Saltau, W. D 417	Sleeman, J. G 251
Carey F. Coombs (rev.) 685	Summary of Radium Treatment	And J. B. Cleland—
	at the Women's Hospital, Mel-	Pseudo-Myxoma Peritonei of
Rheumatism— Acute, and Social Conditions 694	bourne, During the Last Five	Appendiceal Origin and
	Years 403	Mucocele of the Appendix 721
Familial and Latent 102	Years 403 Sampson, C. M. (Practice of	And Rupert Magarey-
Rhind, S. D 454	Physiotherapy, A) (rev.) 546	Gas Infections of the Uterus
Ridler, H. A 133	Sandes, F. P 134, 317, 926	with Jaundice Due to Bacil-
Case of Concealed Accidental	Cancer Research 318	lus Welchii Following Abor-
Hæmorrhage 273	Sangster, W.—	tions 787
Puerperal Infection 118	Nasal Polypi	Smeaton, Bronte 134, 728
Riley, F. R 438, 439, 452, 486, 521	Sarcoma—	Smith, Alan de F. and Russell
Rist, E	Of the Buttock 656	A. Hibbs—
Ritchie, T. Russell 447, 480	Of the Tonsil, Probable 835	Joint Tuberculosis 810
Roberts, A. T 284	Sauer, Louis, W. (Nursery Guide	Smith, C. Nigel 468
Robertson, Carrick, 429, 450	for Mothers and Children's	
Robertson, J. Crawford 133, 248	Nurses) (rev.) 685	Smith, Julian 98
Robertson, J. H. Graham 489, 516, 517	Scantlebury, C 625 Scantlebury, Vera 62, 63 Experiences Abroad with Special	Smith, J. Forest and Donald
Robertson, J. I 799	Scantlebury, Vera 62, 63	Paterson (Modern Methods of
Robertson, T. Brailsford 251, 872	Experiences Abroad with Special	Feeding in Infancy and Child- hood) (rev.) 340
Robertson, W. N. 134, 483, 515, 732	Reference to Infant Welfare 35	100d) (rev.) 340

7.

662 413

873

728

_		_
Smith, R. M.—	Page. Stanton, A. T. (Notes on Malayan	Page. Sutton, Harvey 428, 430, 439,
Bilateral Melanotic Growth of	Culicidæ: Number 20 of	440, 447, 459, 469,
Suprarenal Gland 683	Studies from the Institute of	478, 487, 517, 518, 519
Smith, S. A 592	Medical Research, Kuala	Teaching of Hygiene in Schools,
Smythe, R. B 433	Lumpur, F.M.S.) (rev.) 827 Stanton, Byron L	The
Snake Bite, Treatment of—	Stawell, R. R 429, 470, 471, 512, 626	Swift, Brian H 834
By Keith G. Kerr 873	Steenson, K. R 465	Professor Blair Bell's Lead
By A. MacInnes 771	Stephen, E. H. M 464, 488, 516, 697	Treatment of Malignant
By D. P. O'Brien 909 By Arthur Palmer 873 By R. A. Parker 930	Stephens, H. Douglas 62, 96,	Disease 812 Swords, Crossed, by "The Sarge" 931
Ry R. A. Parker	99, 280, 281, 284, 928 Stewart, A 130, 869	Swords, Crossed, by "The Sarge" 931 Syme, Sir George 134, 350, 427,
By Sydney Pern 874	Stewart, H. Downie 427	449, 462, 479, 480, 728, 730, 732
By Arthur Watkins 665	Stewart, Mervyn 99, 383, 872	Symons, Marc Johnston, Death of 420
Somnolence, Recurrent 384	Still, G. F 694 Stoddart, W. H. B. (Mind and its	Syphilis—
Southby, Robert 63, 100, 281,	Disorders: A Textbook for	Congenital 100 In Children, with Special
382, 383, 586, 588, 870	Students and Practitioners of	Reference to the Efficiency
Pertussis 564 Syphilis in Children, with	Medicine) (rev.) 510 Stokes, H. Lawrence 103, 383,	of Bismuth for Treatment,
Special Reference to the	470, 488, 871, 872	by Robert Southby 357, 382
Efficiency of Bismuth for	Stomach, Acute Postoperative Dila-	Immunity in, by Alan M. Chesney (Vol. XII of Medicine
Treatment 357	tation of the, by Gilbert Brown 542	Monographs) (rev.) 792
Southwood, A. R.— Sympathetic Ramisection 318	Stomatitis, Ulcero-Membranous, by J. Horace Downing 273	Of the Liver 308
	Storey, J. C 660, 926, 927	Serum Diagnosis of, by Precipi- tation: Governing Principles,
Special Correspondence— London Letter 420, 662, 908	Surgical Aspect of the Diseases	Procedure and Clinical Appli-
Books of Interest to Doctors 420	of the Colon 917 Stout, T. D. M 448	cation of the Kahn Precipita-
Fellowship of Medicine, The,	Stowe, W. R 445, 446, 457, 489, 513	tion Test, by R. L. Kahn
420, 908 Lister Centenary 908	Strabismus, Causes of Concomitant 430	(rev.) 650
M. R. C. P. Examinations,	Streptococci, Localization of 465	T
Courses for the 662	Strong, W. M	makes Describe Describe 694
Post-Graduate Work 908	Food Supply for Natives in the	Tabes Dorsalis Pseudo 624 Tachycardia, Paroxysmal 871
Royal College of Physicians, Edinburgh, Membership of	Territory of Papua 607, 665	Tait. J. T
the 663	Stump, C. Witherington 481	Prostatectomy and its After
Royal College of Surgeons of	Sugar, Blood	Results
England, Fellowship of the 663 Royal College of Surgeons,		Talbot, L. S
Edinburgh 663	Summons, W 434, 659	Tasmania, Report of the Depart-
Spasm, Functional, with Some	Surgeons— Ry "Anon" 840	ment of Public Health 661 Taylor, A. L
Hypotonia 385	By "Anon" 840 By "G.P." 874	Taylor, G. H.—
Special Abstract—	By "Kept in the Dark" 874	Mendel and Genius 354
Social Conditions and Acute Rheumatism (Special Report	Fellowships of the Royal College	Tebbutt, A. H 433, 435, 453, 463, 465, 473, 474, 513
by the Medical Research Coun-	Edinburgh 663	Teece, Lennox 416 Teeth, Factors Influencing the
cil of the Privy Council) 694	England 663	
Speech, Defects of 312	Of Australasia, The College of 25, 103	Extraction of— By A. P. R. Moore 113, 131
Spencer, F. M	By E. S. Jackson 285	By Leonard Trott 109, 131
Spider Bite, The Red-backed—	By-Laws 350	Temperature and Pulse Rate, The
By Andrew Balfour 873, 910	Constitution	Relations of, in Disease: A Clinical Study, by D. W. Car-
By E. S. Jackson 524	Council Meeting of 350, 352 Exordium	malt Jones 491
By H. O. Lethbridge 664 By Stewart McKay 626	(Leading Article) 377	Temperature to Pulse Rate, The
By E. H. Miles	Foundations of 349	Relation of 582 Ten Weeks with Chinese Bandits,
By F. A. Rodway 770	Founders 134, 136 First Meeting of 349	by Harvey J. Howard 686
By Arthur Watkins 873 Spiers, Lennox 452	(Leading Article) 243, 651	"The Sarge," Crossed Swords 931
Spinal Abnormality 872	Meetings 134, 135	Therapeutics
Spinal Cord 922	Surgery 56	Thomas, D. J
Spine, Tuberculous Disease of the 164 Splint—	Fundamentals of, the Art of, by John H. Watson (rev.) 685	Thoracoplasty 656
For Fractures of the Lower	Manual of, for Students and	Thring, E. T
Extremity 656, 807	Practitioners, by Albert	us, and Allied Septic and
Measurement 929 Spowers, E. A 418	Carless, Eleventh Edition	Traumatic Lesions of the
Spring, J. F 869	(rev.) 340	Basal Venous Sinuses, by Wells P. Eagleton (rev.) 54
Springthorpe, Guy 587	Surgical— Aspect of the Diseases of the	Thyreoid Enlargement, Including
Sprue or Pernicious Anæmia, by N. Hamilton Fairley 559	Colon, by J. C. Storey 917	Exophthalmic Goître, The
Stacy, H. S	Conscience, by "General Prac-	Treatment of, by Injections of
Stammering as a Psychoneurosis:	titioner"	Quinine and Urea Hydro- chloride into the Thyreoid
A Plea for Corrective Measures,	Susman, Eric—	Gland, by H. G. Loughran 263, 283
by T. Garnet Leary 299 Stanley, Henry Riddell—	Malarial Therapy 806	Thyreoid Gland, Purulent Infiltra- tion in and Around the, by
Death of 320, 419	Sutherland, Tate 200	J. Burton Cleland 790

Watt Webs Weig Weil' Dis West Whit

Whit

Whit Su Who

Wilk Wilk Ar

Page.	Page.	Page
Thyreoid Tumours 473	Tumours-	Ureter, Transplantation into the
Tick Paralysis 548	Of Bone 512	Colon 83
Ticks Wanted, by Stewart McKay 32	Bladder 459	Urological Notes, Random, by Glen
Tilling, H. W 130	Localization of Spinal511	H. Burnell 815, 83
Public Health in Greater Bris-	Malignant 835	Urology
bane 105 Tillyard, R. J. (Insects of Aus-	Thyreoid 473	Urticaria Papulosa 103
Tillyard, R. J. (Insects of Aus-	Turnbull, H. Hume 621, 625, 626	Urticaria Pigmentosa in Adults, by
tralia and New Zealand, The)	Turner, A. Jefferis 442, 459, 469,	K. G. Colquhoun 82 Ussher, G. H
(rev.) 826	488, 516, 521, 868	Uterus, Partial Rupture of, During
Tissue Culture, Chemiotaxis in,	Typhus-Like Epidemics of Aus-	
by W. Moppettt	tralia, The: A Preliminary	Pregnancy with Fatal Intra- Peritoneal Hæmorrhage, by J.
Tissues, Chick, A Convenient	Communication, by W. S.	Burton Cleland 790
Method of Growing, in Vitro,	McGillivray 743	Utz, Leslie and A. J. Fitzgerald—
by W. Moppett 335	**	
Todd, Alan H 344	U	Autogenous Vaccines in Infec-
Todd, Arthur Charles Robert,		tions of the Respiratory Tract 1
Death of 525	Ulcer, Irritable, of the Leg, or	v
Todd, R. H 521, 728, 870 Tonsillectomy with the Guillotine,	Malleolus, and its Cure by	,
by Clive M. Eadie 676	Operation, by C. E. Corlette 782	Vaccines, Autogenous, in Infec-
manusia Dresslamptia 202	Ulcerations, Multiple Superficial	tions of the Respiratory Tract.
Toxemia, Preeclamptic 202	Scarring, of the Small In-	by Leslie Utz and A. J. Fitz-
Tracy-Inglis, R 443, 476 Transfusion in Children, Blood . 488	testine and Duodenal Scar	gorald otz and A. J. Fitz-
Translation of the Ureter into	with Pyloric Obstruction, by	Valassopoulo, A., et Pavlos
Transplantation of the Ureter into	Malcolm Scott and J. B.	Pétridis (Les Hépatites Dysen-
the Colon	Cleland 718	tériques et leur Traitement)
of the Fifth Lumbar 468	Ulrich, F. F 468, 478	(rev.) 860
Treatment, The Elements of Medi-	Ultra-Violet Rays (Leading	Vallack, Arthur S.—
cal, by Robert Hutchison,	Article) 923	"Quackery" 67
(rev.) 375	In General Practice, by W.	Varicella and Herpes Zoster Occur-
Trenerry, E 624, 658	. Annandale Troup (rev.) 614	ring Simultaneously in the
Trinca, A. J 659, 928	In the Treatment of Disease 517	Same Person, by R. L. Thorold
Trinca, Frank -	Ultra-Violet Radiation and Actino-	Grant 100
Ætiology and Treatment of In-	therapy, by E. H. and W. K.	Vaux, Norris W
fantile Eczema, The 152	Russell (rev.) 722	venereal Disease 661.662
Tropical Medicine and Tropical	Universities, The 22	Prevention of, The (Leading
Hygiene, Post-Graduate Course		Prevention of, The (Leading Article)
in 421	University of Otago 66	Verco, Sir Joseph 131
Trott, Leonard 131	Toronto, Centenary 735	Vestibular Reactions 440
Factors Influencing the Extrac-	University Intelligence—	Vincent's Angina 443
tion of Teeth 109	Louvain, Fifth Centenary 523	Viney, Hester and W. Allen
Troup, W. Annandale (Ultra-	Melbourne, Medical Curriculum,	Daley (Popular Education in
Violet Rays in General Prac-	The 28, 64	Public Health) (rev.) 686
tice) (rev.) 614	Sydney 317, 523, 659, 735	Visceroptosis 444, 525
Trumble, H. C 435, 438, 834, 928	Anthropology, Courses in 660	Vitamins [see Food Factors,
Tuberculin, The Use of, in	Appointments 317, 523, 660, 735	Accessory]
Diagnosis 99	Archer, H. R 735	Voluntary Patient, The 484
Tuberculosis 662	Barling, J. E. V 523	***
Acute Pulmonary, in Base of	Byrne, J. M 660 Cancer Research Fund	W
Right Lung, by A. T. Nisbet 755 Experimental Epidemiology of 830		Wada D D 194 410 470 477 774
Hospitalization, by Godias J.	Carter, P. G	Wade, R. B 134, 416, 456, 477, 554 And Norman D. Royle—
	Coen, B 317	
Drolet (rev.) 650 Joint, by Russell A. Hibbs and	Coghlan, C. C 660	
Alan de F. Smith 810	Collins, A. J	Hirschsprung's Disease, The: A New Method 137
Of the Larvnx 837	Dart. R. A	
Pulmonary 659, 661, 834	Dart, R. A	Wakeley, Cecil P. G 340
In Infants and Children 458	Flynn, M. R 660	Waksman, Selman A. and Wilburt
Why it Exists. How it may be	Laidley, J. W. S 317	C. Davison (Enzymes:
and has been Cured and	Lawson, A. Austruther, the	Properties, Distribution,
Prevented, by R. Goulburn	late 659	Methods and Applications)
· Lovell (rev.) 613	MacCormick, Sir Alexander,	(rev.)
Tuberculous Disease—	Unveiling of Portrait by	Wallace, J. A. L 553, 779
Of the Hip Joint 837	H.R.H. the Duke of York 317	Walton, S 722
Of the Knee Joint 165	Macdonald Presentation Fund	Wardlaw, H. S. Halcro-
Of the Spine 164	353, 387, 419, 523, 560, 666	Gravimetric Determination of
Tuberculous-	Petrie, J. M., the late 659	Basal Metabolism, The 506
Glands of the Neck 836	Raymond, R. L 660	Milk of Australian Women, The 318
Lesions 486	Schenk, T 660	
Soldiers, After Histories of 476	Shortland, L. J 660	Warren, C. F
Spine with Calcification of the	Storey, J. C 660	Wassermann Reaction, The 473
Renal Pelvis 837	University of Louvain, Fifth	Clinical Interpretation of the,
Tumour—	Centenary of 523	The, by Robert A. Kilduffe
Brain 609	University of Toronto, Cen-	(rev.)
Cerebral 282, 555, 928	tenary of 735	Watch, N. B 523
Epigastric 837 Of Humerus 835	Wilkinson, H. J 317	Watkins, Arthur—
Of Humerus 835	Upton, W.—	Red Backed Spider Bite, The 873
Of the Cheek 656	Observations on Certain Thera-	Treatment of Snake Bite 665
Of the Kidney, Malignant 99	peutic Measures in Dermato-	Watson, John H. (Fundamentals of the Art of Surgery) (rev.) 685
Of the Thyreoid 164	logical Practice 715	of the Ait of Surgery) (lev.) 000

27.

Page. e . 834 n . 125 . 102 y . 824 . 489

				age.
Watt, M. H			439,	518
Webb, J. Ramsay Webster, Reginald				283
Webster, Reginald		103,	870,	872
Weigall, Gerald				
Weil's Disease				
Diagnosis of, The				
Western Australia,				
Examination Fe	es in			665
White, A. E. Rowd	en an	d Da	vid	
Zacharin-				
Use of "Novasuro	ol," T	he, a	s a	
Powerful Diur	etic	in	the	
Œdema of Card	iac Fa	ilure		273
White, E. R				418
White, J. Renfrew	. 444	468.	469.	
		478,		512
White, N. B. and G	A. F	ave-	_	
Subacute Bacteria				859
Whooping Cough	in I	Hospi	tal.	
Management o	f [80	ee a	lso	
Pertussis],	by	He	nry	
				586
Wilkinson, F. C.				621
Wilkinson, H. J.				317
Argyll-Robertson	Pupil,	The:	A	
	Towar			
				525
			,	

1 450
Wilkinson, J. F 97, 280, 281
Will, C. A 445
Will. Leslie 444, 468, 469
Williams, E. H 489, 517
Williams, F. E 452, 465
Williams, J. R.—
Empyema in Adults: The Results
of an Analysis of the Records
of Empyemata Treated at
Melbourne Hospital, 1919-1924 710
Willis, David A 794 Wilson, Arthur M. 200, 451, 452, 462, 469
Windeyer, J. C 133,
317, 438, 451, 462, 463, 470, 486, 735
Winn, R. Coupland—
Simplification of the Dietetic
Treatment of Diabetes Mel-
litus 321
Wi-Repa, Dr
Women and Children, Traffic in. 907
Wood, A. Jeffreys 443, 464, 516, 517
Woodburn, J. J 312, 315
Woodhill, V. R 473, 474
Workers' Compensation Act, 1926 591
Some Medical Aspects, by R. J.
Millard 562, 592
Workers' Compensation Commis-
sion of New South Wales, The,
by H. C. Rutherford Darling 524

Page
Worrall, R 133, 248
Wound of the Left Eye, Gunshot 621
Wounds of the Eyeball, Penetrating
Wright-Smith, R. J.— Left Subclavian Aneurysm: In-
trathoracic Ligature 754
Wylie, D. S 444, 477
Wynne, T. G 837
X
X Ray Examination of the Stomach, by H. M. Hewlett 328, 348 X Rays, Differential Action of 486
Y
Young, J. A 427
z
Zacharin, David and A. E. Rowden White— Use of "Novasurol," The, as a Powerful Diuretic in the
Œdema of Cardiac Failure 273
Zwar, B. T 315, 348, 586

Anæ

Ane F F

Arg

I

Art

]

В

В

C

INDEX TO ILLUSTRATIONS.

D	Done	
Anæsthetics, by Norman J.	Cercaria Catellæ, by Burton Bradley—	Hospital Practice, by A. E. Brown—
Diagram of First Ether Apparatus	Fig. I: Larvæ from the Bowel of the Mountain Duck 674 Fig. II: Larvæ from Grebe 675	Chart Showing Financial Position of Colac Hospital 296
Aneurysm, Dissecting, by J. Burton Cleland— Fig. I: Dissecting Aneurysm 539	Chick Tissue in Vitro, Growth of, by W. Moppett—	Infant Welfare, by Vera Scantle- bury—
Fig. II: Heart Bisected Showing Aneurysm 539 Fig. III: Aneurysm in Neigh-	Fig. I: Cultures of Pigment Cells from Retina of Chick 336 Fig. II: Migrating Cells in a	Graph I: Decline of Infantile Mortality 37
bourhood of Diaphragm . 540	Glucose Preparation 336 Child, The Difficult, by John	Graph II: Infantile Mortality in Western Australia 38
Argyll-Robertson Pupil, The, by Herbert J. Wilkinson—	Bostock— Diagram of Alternating States 709	Graph III: Infantile Mortality in Victoria 38 Graph IV: Infantile Mortality
Fig. I: Diagram of Nerve Paths 268 Fig. II: Cross Sections of the	Cholecystitis, by Alan Newton— Fig. X: Method of Reflection of	in New South Wales 38 Graph V: Infantile Mortality in
Mesencephalon	Rectus Muscle 76 Fig. XI: Exposure of Field for	Queensland 39 Graph VI: Infantile Mortality
grams of Convergence of Eye (Experimental) 270	Cholecystectomy 76 Fig. XII: Reflection of Large	in South Australia 39 Graph VII: Infantile Mortality
Figs. VII, VIII, IX, X, XI and XII: The Same 271	Peritoneal Flaps 77 Fig. XIII: Closure of Wound 77	in New Zealand 39 Graph VIII: Decrease in Infant
Figs. XIII and XIV: The Same 272 Arthritis of the Knee Joint, Acute	Diabetes, by Basil Corkill—	Death Rates 46 Graph IX: Infant Death Rates
Suppurative, by Balcombe Quick—	Graph I: Sugar Curve, Effect of Glucose 47	in Victoria 41 Graph X: Effect of Climate on
Fig. I: Vertical Section of Knee Joint	Graph II: Sugar Curve, Effect of Lævulose 47	Infant Mortality 41 Graph XI: Infant Deaths in
Joint	Graph III: Sugar Curve in Moderately Severe Diabetes 48	Victoria and New Zealand 42 Graphs XII and XIII: Average Weights of New Zealand
Fig. III: Knee Joint Injected with Bismuth 393 Fig. IV:Synovial Membrane of	Graph IV: Sugar Curve in Glycosuria 48	Babies 45
the Knee	Graph V: Lag Curve 49	Influenza, by Frank R. Kerr— Graph Showing Deaths from
Fig. VI: Knee Joint Opened by Transverse Arthrotomy 395	Electrocardiograms, by Eric F. Gartrell— Fig. I: Diagram of Electro-	Influenza 749
Fig. VII: The Same with Carrel- Dakin Tube in Position 395	cardiograph 529 Fig. II: Electrocardiogram—	Mental Deficiency, by John Bostock—
Basal Metabolism, by H. S. Halcro	Normal Rhythm 529 Fig. III: Electrocardiogram—	Fig. I: Hydrocephaly 258 Fig. II: Microcephaly 258
Wardlaw— Fig. I: Apparatus 507	Right Bundle Branch Lesion 530 Fig. IV: Electrocardiogram—	Fig. III: Rounded Mongolian Head 258
Fig. II: Chart for Calculating Basal Metabolic Rate 509	Partial Heart Block 530 Fig. V: Electrocardiogram—	Fig. IV: Box-shaped Head of Hypertrophic Cerebral
Blastomycosis, by J. Burton Cleland—	Partial Heart Block and Sino- auricular Block 530	Sclerosis
Drawing of Blastomycotic Cysts 339	Fig. VI: Electrocardiogram— Complete Heart Block 530 Fig. VII: Electrocardiogram—	Figs. I, II and III: Genealogical Tree of Mental Defectives 326
Bull, Richard Joseph 839	Auricular Flutter 530 Fig. VIII: Electrocardiogram—	Paragonimiasis, by R. W. Cilento
Capillaries, Surface, by George E. Brown and Grace M. Roth—	Auricular Extrasystole 531 Fig. IX: Electrocardiogram—	and T. C. Backhouse— Figs. I and II: Paragonimus
Fig. I: Photomicrograph of Normal Skin Capillary 500 Fig. II: Curve of Length of	Auricular Fibrillation 531 Fig. X: Electrocardiogram—	westermanni 80 Fig. III: The Same 81
Visible Capillary Loop 501 Fig. III: Curve of Gradual	Auricular Fibrillation and a Paroxysm of Tachycardia 531	Paraplegia, Spastic, Treatment of
Decrease of Capillary Blood	Fiaschi, Thomas Henry 733	Congenital, by Sympathetic Ramisection, by N. D. Royle—
Flow 501 Fig. IV: Photomicrograph of Nail-Fold Capillaries in	Food Supply for Natives, by W. M. Strong—	Fig. I: Diagram of Knee Jerks 634 Figs. II and III: Contracture 638
Raynaud's Disease 503 Fig. V: Photomicrograph of	Chart of Mortality from Consumption 609	Pelvis, Anatomy of the Female, by F. A. Maguire—
Capillary Loops in Polycythæmia Vera 504	Hookworms, by G. M. Heydon—	Pelvis II: Plane of Section 215 Pelvis III: Plane of Section 215 Pelvis V: Plane of Section
Fig. VI: Sketch of the Areas of the Capillary Tops in Poly-	Fig. 1: Anterior Extremities of Mature Larvæ of Necator and	Pelvis V: Plane of Section, Right
cythæmia Vera Before and After Treatment 505	Ancylostoma 533 Fig. II: Outlines of the Same 533	Front 218

Page Public Health in Greater Brisbane, by H. W. Tilling— Diagram Showing Organization of Department of Health 107 Purpura Hæmorrhagica, by Henry Shannon— Ulcers Resulting from Necrosis	Page Temperature and Pulse Rate, Relations of, by D. W. Carmalt Jones—Continued. Charts XI and XIA: Pneumonia 495 Chart XII: Typhus Fever 495 Chart XIII: Streptococcal Septicæmia 495 Chart XIV: Influenza 495	Page Temperature and Pulse Rate, Relations of, by D. W. Carmalt Jones—Continued. Chart XXVI: Fractured Skull 497 Chart XXVII: Tuberculous Pleurisy 497 Chart XXVIII: Malignant
of Ecchymoses	Charts XV, XVA and XVB: Gunshot Wound of the Chest	Pleurisy
Charts VA and VB: Pneumonia 492 Chart VI: General Sepsis	Chart XXI: Bronchiectasis . 496 Chart XXII: Typhus Fever . 496 Chart XXIII: Sarcoma of Vertebral Column 497 Chart XXIV: Diabetic Gangrene 497 Chart XXV: Aplastic Anæmia 497	Fig. I: Large Irritable Ulcer 784 Fig. II: Two Irritable Ulcers of Malleolus 785 University of Otago, New Medical School for the 66

age

498 498

784 785 66

SPECIAL PLATES.

Aneurysm, Left Subclavian, by R. J. Wright Smith—	Lister to face page 864	Rodent Ulcer, by E. H. Moles- worth—Continued.
Skiagram of Subclavian An- eurysm to face page 753	Peanut Impacted in the Right Bronchus, by J. M. Baxter and Colin Macdonald—	Fig. VI: Slightly Later Development to face page
Cholecystitis, by Alan Newton-	Fig. I: Skiagram showing Ap-	Fig.VII: Rodent Mass Invad- ing Deeper Parts of Seb-
Fig. I: Acute Cholecystitis	pearances before Removal of the Foreign Body—Chest at	aceous Follicle, to face page
to face page 78 Fig. II: Strawberry Gall Blad-	Full Inspiration to face page 752	Fig. VIII: Cavity Formation
der to face page 78	Fig. II: The Same—Chest at Full Expiration to face page 752	in Rodent Tumour to face page
Fig. III: Granulation Tissue in Gall Bladder to face page 78	Fig. III: Skiagram showing Ap-	Fig. VIIIa: High Power Mag-
Gall Bladder to face page 78 Figs. IV and V: Chronic Chole-	pearances after Removal of	nification of the Same Tum-
cystitis to face page 78	the Foreign Body—Chest at Full Inspiration to face page 752	our to face page Fig. IX: Large Club-like
Fig. VI: Early Carcinoma of Mucous Membrane of Gall	Fig. IV: The Same-Chest at	Masses near Epithelial Sur-
Bladder to face page 78	Full Expiration to face page 752	face to face page
Fig. VII: Normal Gall Bladder Shadow to face page 78	Pelvis, Anatomy of the Female, by	Fig. X: Rodent Tumour show- ing Epithelial Connexion
Shadow to face page 78 Fig. VIII: The Same Superim-	F. A. Maguire—	to face page
posed on Renal Shadow	Plates of Sections of Pelves— Pelvis I page 225, 226	Fig. XI: High Power Mag-
to face page 79 Fig. IX: Shadow of Stone Im-	Pelvis II page 226, 227	nification of Mature Tumour with Club-like Masses con-
pacted in Cystic Duct	Pelvis III page 227	nected with Epithelium
to face page 79	Pelvis IV page 228 Pelvis V page 228, 229	to face page
Cholecystography, by J. G. Ed-	Pelvis VI page 229	Figs. XII and XIII: Tumour Revealing Whorling and Ir-
wards—	Pelvis VII page 229, 230 Pelvis VIII page 230	regular Cavities, to face page
Fig. I: Skiagram of Gall Blad- der not Filled to face page 79	Pelvis IX page 231	Fig. XIV: Semicystic Tumour
Fig. II: Skiagram of Large Dis-	Pelvis X page 231, 232 Pelvis XI page 232, 233	to face page Fig. XV: Sebaceous Tumour
tended Gall Bladder to face page 79	Pelvis XI page 232, 233 Pelvis XII page 233	to face page
Fig. III: Skiagram of Gall-	Pelvis XIII page 233	Figs. XVI, XVII and XVIII:
Bladder Partly Filled to face page 79	Pelvis XIV page 234 Pelvis XV page 234	Rodent Tumours with Mul- tinucleated Cells, to face page
to face page 79 Fig. IV: Skiagram of Small Con-	Pelvis XVI page 234	Fig. XIX: Sebaceous Tumour
tracted Gall Bladder	Perthes's Disease, by Alan Pryde	probably arising from Sur-
to face page 79 Fig. V: Skiagram of Filled Gall	and W. P. Holman-	face Epithelium, to face page Fig. XX: Squamous Epitheli-
Bladder with Stones in Cystic	Figs. I and II: Skiagrams of Pelvis to face page 753	oma with Typical Cell Nests
Duct to face page 79		to face page
Hirschsprung's Disease, by R. B.	Rodent Ulcer, by E. H. Moles- worth—	Fig. XXI: Epithelial Down- growths with Cell Nests and
Wade and Norman D. Royle-	Photomicrographs—	only a Few of the Elements
Fig. I: Skiagram After Com-	Fig. I: Early Rodent Ulcer	of the Former Tumour to face page
plete Colectomy to face page 138 Fig. II: Skiagram Showing Even	near a Sebaceous Unit to face page 896	
Distension of Colon	Figs. II, III and IV: Early	Tuberculosis, Pulmonary, in the Base of the Right Lung, by
to face page 139 Fig. III:Skiagram Taken Three	Rodent Tumours, to face page 896 Fig. V: Curtain or Festoon-	A. T. Nisbet—
Months after Ramisection	like Structures in Rodent	Skiagram of the Base of Right
to face page 139	Tumour to face page 896	Lung to face page

	worth-Continued.
Peanut Impacted in the Right Bronchus, by J. M. Baxter and	Fig. VI: Slightly Later Development to face page 896
Colin Macdonald—	Fig.VII: Rodent Mass Invad-
Fig. I: Skiagram showing Ap-	ing Deeper Parts of Seb-
pearances before Removal of	aceous Follicle, to face page 896
the Foreign Body-Chest at	
Full Inspiration to face page 752	Fig. VIII: Cavity Formation
Fig. II: The Same—Chest at	in Rodent Tumour
Full Expiration to face page 752	to face page 896
Fig. III: Skiagram showing Ap-	Fig. VIIIa: High Power Mag-
pearances after Removal of	nification of the Same Tum-
the Foreign Body—Chest at	our to face page 896
Full Inspiration to face page 752	Fig. IX: Large Club-like
Fig. IV: The Same—Chest at	Masses near Epithelial Sur-
Full Expiration to face page 752	face to face page 896
Dolair Anatomy of the Homole by	Fig. X: Rodent Tumour show-
Pelvis, Anatomy of the Female, by	ing Epithelial Connexion
F. A. Maguire—	to face page 896
Plates of Sections of Pelves-	Fig. XI: High Power Mag-
Pelvis I page 225, 226	nification of Mature Tumour
Pelvis II page 226, 227	with Club-like Masses con-
Pelvis III page 227	nected with Epithelium
Pelvis IV page 228	to face page 896
Pelvis V page 228, 229	Figs. XII and XIII: Tumour
Pelvis VI page 229	Revealing Whorling and Ir-
Pelvis VII page 229, 230	regular Cavities, to face page 897
Pelvis VIII page 230	
Pelvis IX page 231	Fig. XIV: Semicystic Tumour
Pelvis X page 231, 232	to face page 897
Pelvis XI page 232, 233	Fig. XV: Sebaceous Tumour
Pelvis XII page 233	to face page 897
Pelvis XIII page 233	Figs. XVI, XVII and XVIII:
Pelvis XIV page 234	Rodent Tumours with Mul-
Pelvis XV page 234	tinucleated Cells, to face page 897
Pelvis XVI page 234	Fig. XIX: Sebaceous Tumour
Perthes's Disease, by Alan Pryde	probably arising from Sur-
and W. P. Holman-	face Epithelium, to face page 897
Figs. I and II: Skiagrams of	Fig. XX: Squamous Epitheli-
Pelvis to face page 753	oma with Typical Cell Nests
	to face page 897
Rodent Ulcer, by E. H. Moles-	Fig. XXI: Epithelial Down-
worth-	growths with Cell Nests and
Photomicrographs—	only a Few of the Elements
Fig. I: Early Rodent Ulcer	of the Former Tumour
near a Sebaceous Unit	to face page 897
to face page 896	
Figs. II, III and IV: Early	Tuberculosis, Pulmonary, in the
Rodent Tumours, to face page 896	Base of the Right Lung, by
Fig. V: Curtain or Festoon-	A. T. Nisbet—
like Structures in Rodent	Skiagram of the Base of Right
Tumour to face page 896	Lung to face page 753

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